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ABSTRACT

Intended to inform policymaking in the public and private sectors, this booklet compiles secondary data for 54 health status indicators. The book provides both graphical and textual summaries of data, and addresses long-term trends where applicable. Data are presented for the target populations of Title V funding: infants, children, adolescents, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. Following the introduction, which discusses trends and issues in children's health, the booklet has six sections: (1) "Population Characteristics," including children in poverty, maternal age, working mothers, and school dropouts; (2) "Health Status," discussing the health issues related to infants, children, and adolescents; (3) "Health Services and Utilization," including health care financing, vaccination coverage levels, physician visits, service utilization by children with chronic conditions, hospital utilization, and prenatal care; (4) "State-Specific Data," including data tables on infant and neonatal mortality, prenatal care, low birth weight, births to women under 18, Medicaid information, and health care financing; (5) "City Data," focusing on comparisons between cities with populations over 100,000 and national data on infant mortality, low birth weight, and prenatal care; and (6) "Progress towards Healthy People 2000," summarizing progress toward several prevention objectives. (Contains 32 references.) (HTH)

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CHILD HEALTH USA 1999

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PREFACE

Child Health USA 1999 is the tenth annual report on the health status and service needs of America's children. This book is a compilation of secondary data for 54 health status indicators. It provides both graphical and textual summaries of data and addresses long-term trends where applicable.

Child Health USA is published to provide the most current data available for public health professionals and other individuals in the private and public sectors. The succinct format of the book is intended to facilitate the use of the information as a snapshot of measures of the health of children in the United States.

Data are presented for the target populations of Title V funding: infants, children, adolescents, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. This information provides the reader with a multi-dimensional perspective of the health of children in the United States, in accordance with the World Health Organization definition of health: "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

The first section, *Population Characteristics*, presents statistics on factors that influence the well-being of children. The second section, entitled *Health Status*, contains vital statistics and health behavior information for infants, children, adolescents, and women of childbearing age. The third section, *Health Services Utilization*, contains data regarding health care financing and newly implemented health policies. The fourth and fifth sections contain information on selected indicators at state and city levels. This edition also includes a special section that cross-references 24 indicators with their respective Healthy People 2000 Objectives.

We hope the information provided in this book will be helpful to policy and decision-makers responsible for implementing or expanding programs that affect the health of children in the United States.

Maternal and Child Health Bureau
Health Resources and Services Administration

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INTRODUCTION

The progress we have made over the course of the past century in assuring the health of mothers and children is astounding. Rates of infant, child, and maternal mortality have declined substantially in the last hundred years; widespread immunization and improved sanitation and nutrition have contributed to vast reductions in the rate of infectious disease; and medical and technological advances have led to longer, more productive lives for children with chronic diseases. At the same time, new threats to children's health—such as motor vehicle crashes, substance abuse, gun violence, and HIV/AIDS—have arisen or become more common, and racial and ethnic disparities in child health are still evident.

The indicators in this book reflect this mixed record of progress over the past hundred years. For example, the infant mortality rate in the United States continues to decline; the 1997 rate of 7.2 deaths per 1,000 live births was the lowest ever reported. However, the rates among African American infants continues to be more than twice those of white infants, and the U.S. rates is still one of the highest in the industrialized world. Similarly, the likelihood that a woman will die in childbirth has dropped dramatically, and in 1997 there were only 8.4 maternal deaths for every 100,000 live births. However, among African American women, this rate is 20.8 deaths per 100,000 live births, more than three times the rate among white women.

We have seen less progress in improving the health of infants at birth. The rate of low birth weight, a weight of 2500 grams (about 5.5 pounds) or less, remains stable at 7.5 percent of all births, and the rate among African American infants is still about twice that of whites. Infants born at very low birth weight, a weight of 1500 grams (about 3.3 pounds) or less, continue to represent 1.4 percent of all births. These infants are the most susceptible to physical disabilities, developmental delays, and infant death.

These outcomes continue despite increases in women's access to and use of prenatal care. In 1997, more than 82 percent of pregnant women began prenatal care during the first three months of pregnancy, and this rate increased for the eighth consecutive year. However, African American women and young mothers were still less likely to receive early prenatal care than were older, white women. Four percent of infants are born to women who receive no prenatal care or who do not begin care until the third trimester.

Rates of breastfeeding have also shown improvement in recent years. Breast milk has a number of preventive health benefits for both mother and child. The benefits of breastfeeding include prevention of diarrhea and infections in infants, as well as long-term preventive effects for the mother, including earlier return to pre-pregnancy weight and reduced risk of premenopausal breast cancer and osteoporosis. In 1997, 62 percent of mothers reported breastfeeding their babies right after delivery, the highest rate in recent years. However, rates of breastfeeding decline dramatically after the initial months of life, and only 26 percent report that they are still breastfeeding their infants at 6 months of age. These rates are even lower

among African American women and young mothers; 41 percent of African American women report breastfeeding in the hospital, and only 14 breastfed at 6 months.

The risks that children face after infancy have changed substantially over the years. Where children a century ago risked death from infectious disease, the major threat to children's lives at the end of the 20th century is injury. Nearly all of the major causes of death from injury are preventable, including motor vehicle crashes, firearms, and drowning. In 1997, injuries caused the deaths of 2,005 children under the age of 15. The leading causes of these deaths were motor vehicle crashes (the cause of 5.0 deaths per 100,000 children ages 1-4 and 5.1 deaths per 100,000 children ages 5-14), firearms (0.5 deaths per 100,000 children ages 1-4 and 1.4 deaths per 100,000 children ages 5-14), and drowning (3.0 deaths per 100,000 children ages 1-4 and 1.1 deaths per 100,000 children ages 5-14). Other leading causes of death in childhood are birth defects (causing 3.8 deaths per 100,000 children ages 1-4 and 1.3 deaths per 100,000 children ages 5-14) and malignant neoplasms, or cancer (causing 2.9 deaths per 100,000 children ages 1-4 and 2.7 deaths per 100,000 children ages 5-14).

The near-elimination of infectious disease as a cause of death in childhood is partially due to the rise in the rate of immunization of young children. The percentage of children who receive a full series of immunizations—including those for measles, mumps, rubella (German measles), polio, tetanus, pertussis (whooping cough), and Haemophilus influenzae type b, the bacterium that causes meningitis—reached the highest level ever recorded in 1997-1998, with 79 percent of children aged 19-35 months fully immunized. Moreover, polio has nearly been eradicated, and a new vaccine for varicella (chicken pox) promises to reduce the rates of yet another once- common but often severe childhood illness.

An exception to the general decline in the prevalence of infectious disease is the ongoing threat of pediatric Acquired Immune Deficiency Syndrome (AIDS). Only 382 new cases of AIDS were reported in 1998, a number that continues to decline each year. However, more than 80 percent of reported cases of pediatric AIDS are in African American and Hispanic children, emphasizing the need to target prevention efforts to minority communities and to increase access to treatment for HIV-positive pregnant women.

The major health risks experienced by children continue in adolescence. Although the adolescent death rate from cancer, birth defects, and heart disease are similar to those among young children, the risk of death from injury among adolescents is nearly seven times that of younger children, with 34.6 deaths per 100,000 teens aged 15-19. The leading causes of these injury deaths are motor vehicle crashes (27.3 deaths per 100,000 children aged 15-19) and firearms (18.8 deaths per 100,000 children aged 15-19).

HIV/AIDS is another significant threat to the health of adolescents and young adults. In 1998, 297 cases of AIDS were reported among teens (under age 20) and 1,501 were reported among young adults (ages 20-24), many of whom were infected with HIV during their teen years. Of the newly-reported cases in adolescents, 61 percent were in young men, for whom the major identified source of exposure was having sex with men. Among young women, the major source of HIV transmission is heterosexual contact. Clearly, efforts must continue to educate sexually active teens and young

adults of both sexes on prevention of HIV and other sexually transmitted diseases.

The declining rate of childbearing among adolescents is a sign of the success of recent efforts to educate teens on sexual responsibility. Unplanned childbearing early in life presents a major obstacle to education and economic independence, and often begins a cycle of poverty from which children never recover. Rates of childbearing among adolescents have declined steadily from 1991 to 1997, with the greatest decreases seen among African American teens: the 1997 birth rate among African American women aged 15-19 was 88.2 births per 1,000 young women, the lowest rate ever recorded. Nonetheless, a total of 483,220 babies were born to 15- to 19-year-olds in 1997, and 10,121 were born to mothers under age 15. Since young mothers are less likely to receive timely prenatal care, and more likely to expose their infants to risks such as prenatal smoking and inadequate weight gain, prevention of unintended pregnancy can contribute greatly to improved infant health.

Finally, efforts must continue to encourage adolescents to adopt good health habits and practices that they will carry with them into adulthood. One of the most important of these is the reduction in the rate of smoking among teens. Unfortunately, this is one indicator where progress is not being made. Although the rate of smoking among teens declined slightly between 1997 and 1998, we have seen substantial increases in the rate of smoking since 1991 among teens in nearly every racial and ethnic group and in every geographic region. Tobacco use, when begun in adolescence, often becomes a lifelong addiction with serious health consequences for smokers and their families.

The statistics presented here paint a picture of continuing progress toward the goal of healthy children and families, but we still have a long way to go in many areas. On the National, state and community levels, we continue to monitor our progress using the Healthy People 2000 Objectives for the Nation. These 319 objectives, developed in 1990 by a consortium of government, voluntary, and professional organizations, are targeted toward 22 priority areas, such as family planning, nutrition, and maternal and infant health. In addition to these national goals, 42 states and territories have established their own statewide objectives. Although the methods used to calculate the specific statistics in this book may not precisely coincide with the way these national and state-level objectives are measured, the information presented here will provide readers with timely and accurate data that allows for an overview of progress toward the nation's maternal and child health objectives for the year 2000.

POPULATION CHARACTERISTICS

Socio-demographic characteristics provide a comprehensive picture of the country's diverse maternal and child population. Through the year 2000, the proportion of children ages 21 and below is projected to remain at 35 percent.

At the national, state, and local levels, policy-makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy-makers can then tailor programs to meet the needs of those populations.

The following section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. These include age, poverty status, living arrangements by head of household, school dropout rates, and child care trends.

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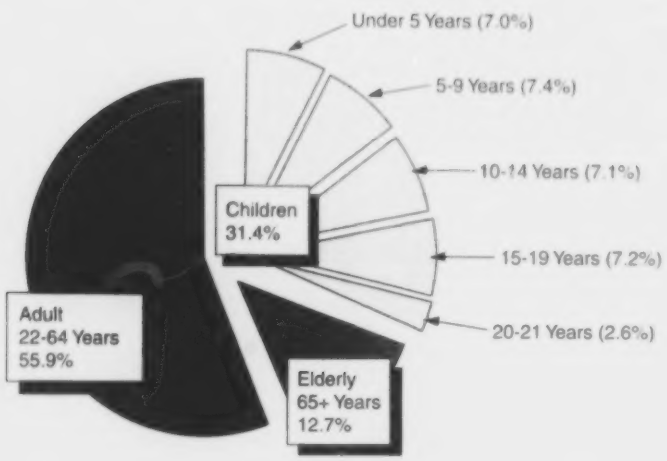
U.S. RESIDENT POPULATION BY AGE GROUP: JULY 1, 1998

Source (L1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1998, the 84 million children through the age of 21 in the United States represented 31.4 percent of the total population. Persons aged 65 and over represented 12.7 percent of the total population. The median age in the United States for all races was 35.2

Since 1990, the number of children under 5 years of age has increased by .6 percent. The number of children ages 5-19 years has increased by 10.7 percent. Through the year 2000, the proportion of children through the age of 21 is projected to remain between 31.5 percent and 31.6 percent.

CHILDREN IN POVERTY

In 1997, there were 13.4 million related* children under 18 years of age living in families with income below the Federal poverty level of $16,400** for a family of four. This population comprised 19.2 percent of all related children living in families, or nearly one in every five children. Among black and Hispanic children, two in five children are poor.

Although the number of children in poverty has fallen by approximately 342,000 since 1996, this number still represents 2.3 million more children than were reported to be living in poverty in 1980. Over this same period, the number of persons 65 years of age and over living in poverty decreased by almost 500,000.

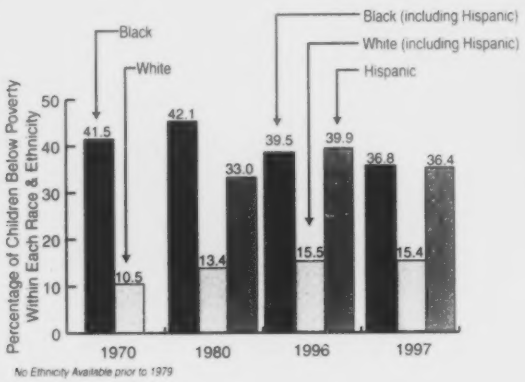
Of the 13.4 million related children under 18 years of age living in poverty, 59 percent live in homes headed by a single mother, 35.5 percent live in homes headed by married parents, and 5.5 percent live in families with other compositions.

*Related children in a family includes householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.

**Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous calendar year.

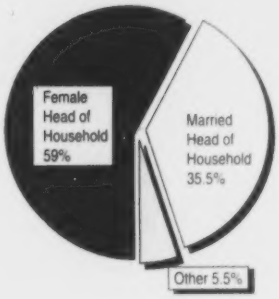
RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL: 1997

Source (L2): U.S. Bureau of the Census



RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL, BY HOUSEHOLD STATUS: 1997

Source (L2): U.S. Bureau of the Census



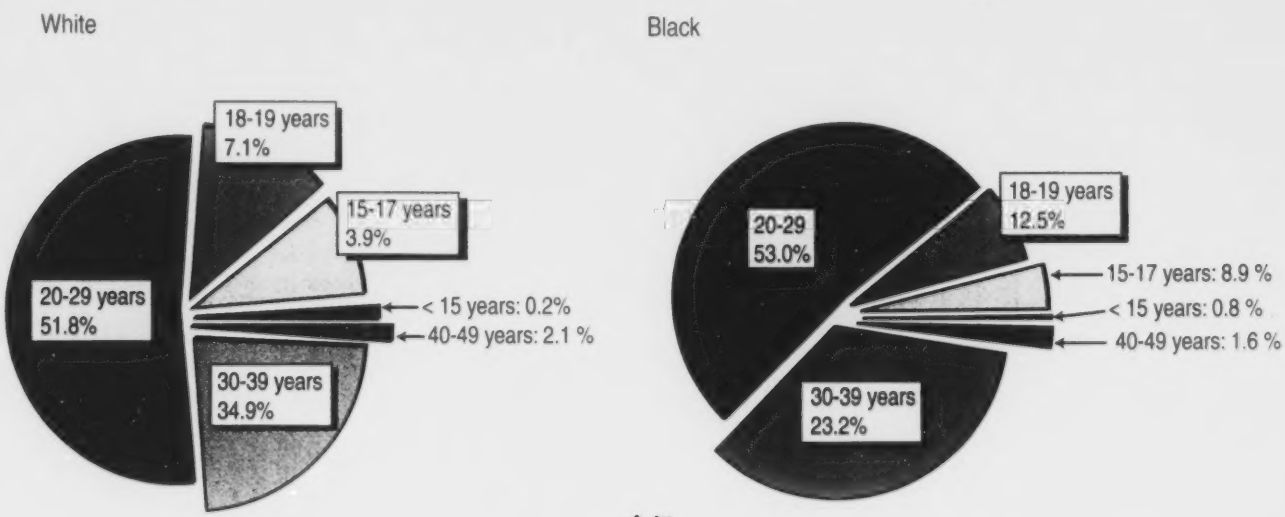
MATERNAL AGE

In 1997, while birth rates among teenagers continued to decline, birth rates for women in their thirties continued to increase and rates for women in their twenties showed a small increase. Of all births in 1997, just over half were to women in their twenties, one third were to women in their thirties, and 12.7 percent were to teens. The remaining 2 percent of births were to women in their forties.

Among both black and white women, more than half of births in 1997 were to women in their twenties. The percentage of births that are to women in their teens, however, is almost twice as high among blacks as among whites.

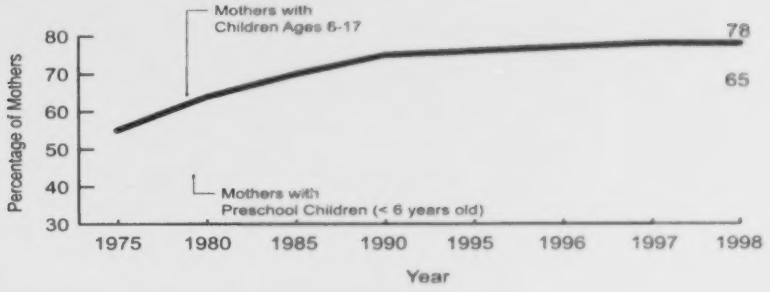
PERCENT DISTRIBUTION OF BIRTHS BY MATERNAL AGE, BY RACE, 1997

Source (13): National Center for Health Statistics



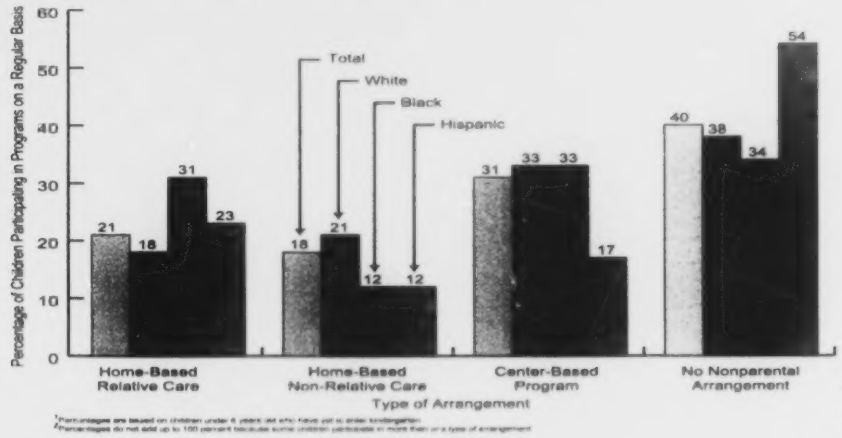
MOTHERS IN THE WORK FORCE: 1975–1998

Source (I.4): U.S. Bureau of Labor Statistics



PLACE OF CARE FOR PRESCHOOL-AGED CHILDREN: 1995

Source (I.5): U.S. Department of Education, National Center for Education Statistics



WORKING MOTHERS

In 1998, 65 percent of mothers with preschool aged children (younger than 6 years) were in the labor force (either employed or looking for work), and 61 percent were actually employed. Of those mothers, 70 percent were employed full-time and 30 percent worked part-time.

Of women with children ages 6-17, 78 percent were in the labor force in 1998 and 74 percent were actually employed. Of employed mothers, 77 percent worked full-time and 23 percent worked part-time.

**Data for 1994 and 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.*

CHILD CARE AND EARLY EDUCATION

In 1995, approximately 6 out of 10 children younger than age six who had not yet started kindergarten were in a child care setting or received education from adults other than their parents. More than 12.9 million infants, toddlers, and preschool children receive child care and early education services. Participation in nonparental care and education increases with the age of the child, household income, and mothers' education, and is higher for children whose mothers work.

SCHOOL DROPOUTS

As of October 1997, approximately 454,000 youths ages 15–24 had dropped out of high school in the previous 12 months. Those who dropped out of high school during this period represented 4.6 percent of students enrolled in high school in 1996.

In 1997, Hispanic students were the most likely to drop out, and dropouts represented nearly one-fourth of Hispanic young adults. However, the 1997 data represent a 4 percent decrease from the 1996 Hispanic dropout rates. Both the white and black dropout rates increased slightly between 1996 and 1997.

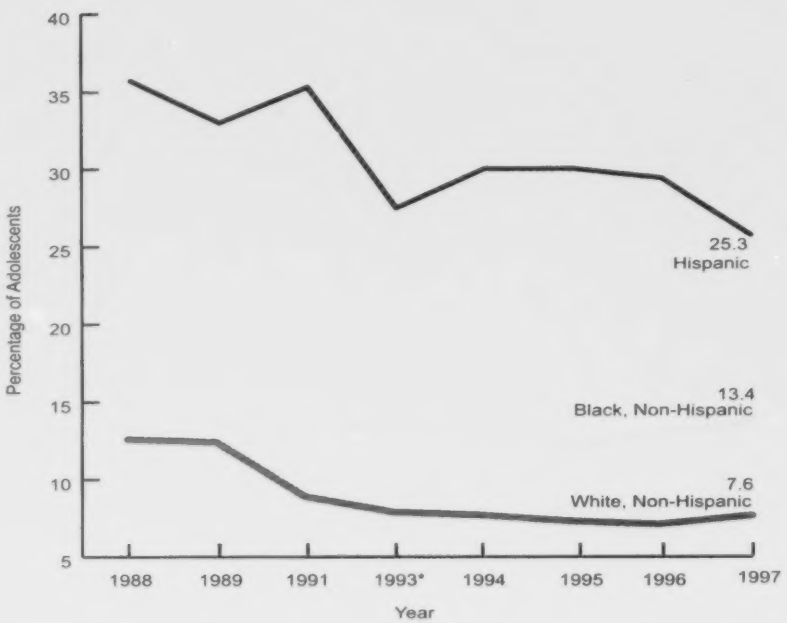
Those students most likely to drop out of school in 1997 were Hispanic youth; students who remain in school after the majority of their age cohort has left; and students over the age of 19. Also, students living in low-income families were seven times more likely to drop out of high school than those in higher-income families.

Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

**Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.*

STATUS SCHOOL DROPOUT RATES FOR AGES 16–24 BY RACE/ETHNICITY: 1988–1997

Source (I.6): U.S. Department of Education



HEALTH STATUS

The systematic assessment of the health status of children enables health professionals to determine the impact of past and current health intervention and prevention programs. Program planners and policy-makers identify trends by examining and comparing information from one data collection year to the next. Although indicators are often assessed on an annual basis, some surveillance systems may only collect data every two, three, or five years.

In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal and child population that are affected by, or in need of, specific health services.

LOW BIRTH WEIGHT

In 1997, 291,154 babies (7.5 percent of all live births) were of low birth weight, weighing less than 2,500 grams, or about 5.5 pounds, at birth.

The percentage of low birth weight births rose from a low of 6.8 percent in 1985 to 7.5 percent in 1997. Low birth weight increased among white mothers from 6.2 percent to 6.5 percent. Although the rate of low birth weight is still more than twice as high among infants born to black women (13.0 percent), the rate of low birth weight for black infants has been dropping since 1992.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long term disabilities or to die during the first year of life than are infants of normal weight.

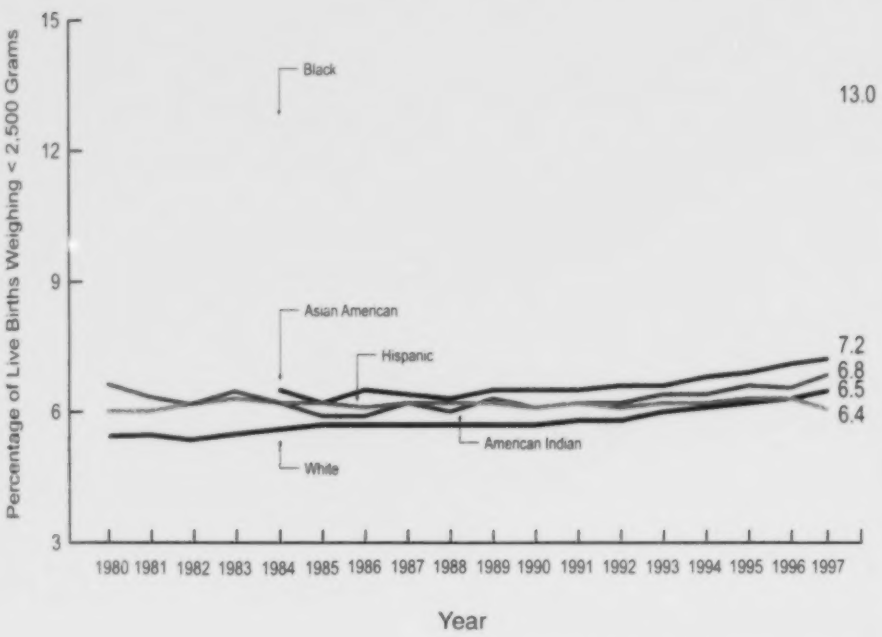
In 1997, 12.1 percent of infants born to smokers were of low birth weight, compared with 7.1 percent of births to nonsmokers. The nearly twofold differential has been observed since 1989 among both black and white infants. Other factors associated with increased risk of low birth weight include poverty, low level of educational attainment and minority status.

Note: 1980-1988 data based on race of child; 1989-1997 data based on race of mother.

**Hispanic can be of any race.*

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT BY RACE: 1980–1997

Source (II.1): National Center for Health Statistics



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VERY LOW BIRTH WEIGHT

In 1997, rates of very low birth weight remained virtually unchanged at 1.4 percent of live births for U.S. women overall.

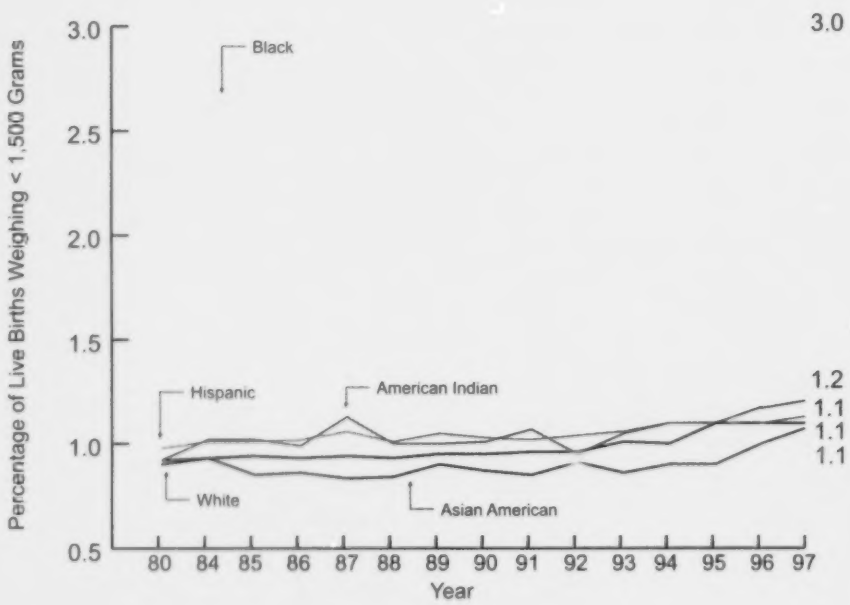
Although infants weighing less than 1500 grams (about 3.3 pounds) account for a small percentage of births, they account for up to half of the deaths of newborns. Nearly 9 of 10 of the very smallest infants—those with birth weights of less than 500 grams—die within the first year of life.

Very low birth weight infants who survive are at significantly increased risk of severe problems, including physical and visual difficulties, developmental delays and cognitive impairment requiring increased levels of medical, educational and parental care.

The rate of very low birth weight among black babies is almost thee times as high as that among whites, and is more than twice the rate for the total birth population. This disparity is a major contributor to the disparity in infant mortality rates between black and white infants.

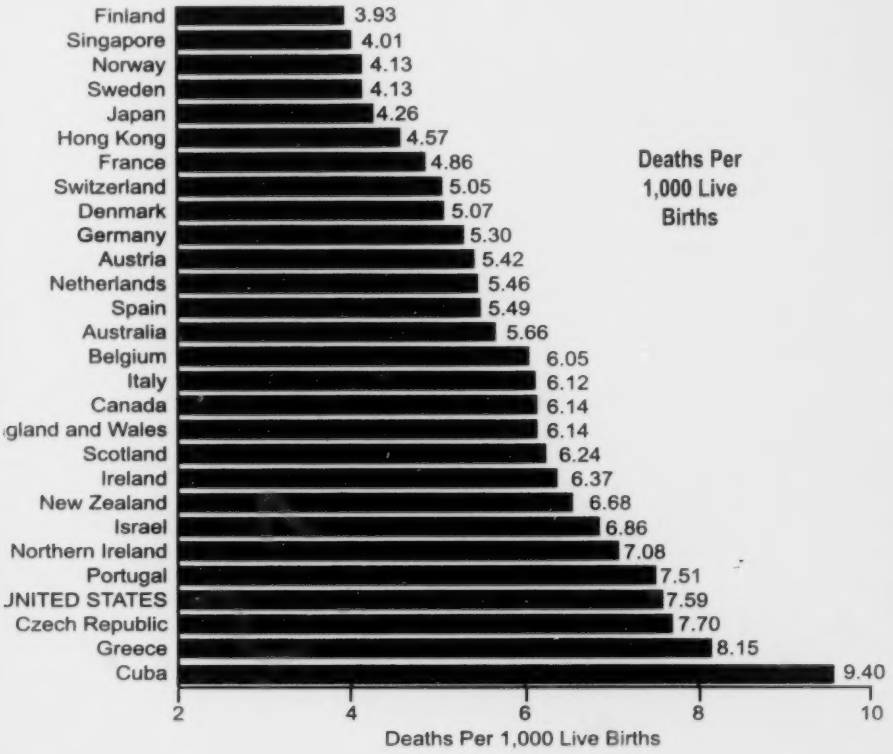
PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT BY RACE: 1980–1997

Source (ILL): National Center for Health Statistics



COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1995

Source (II.2): National Center for Health Statistics



COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the Nation again ranked 25th among industrialized countries in 1995.

In 1995, four nations reported lower rates of infant mortality than Japan, which had the lowest rate in the world from 1985 to 1994. The risk of a Finnish child dying in infancy (3.93 per 1,000) was 48 percent lower than that observed in the United States (7.6 per 1,000 live births).

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INFANT MORTALITY

In 1997, 28,045 infants died before their first birthday. The infant mortality rate was 7.2 deaths per 1,000 live births. This figure represents a decline of 1.4 percent from the rate of 7.3 for the previous year.

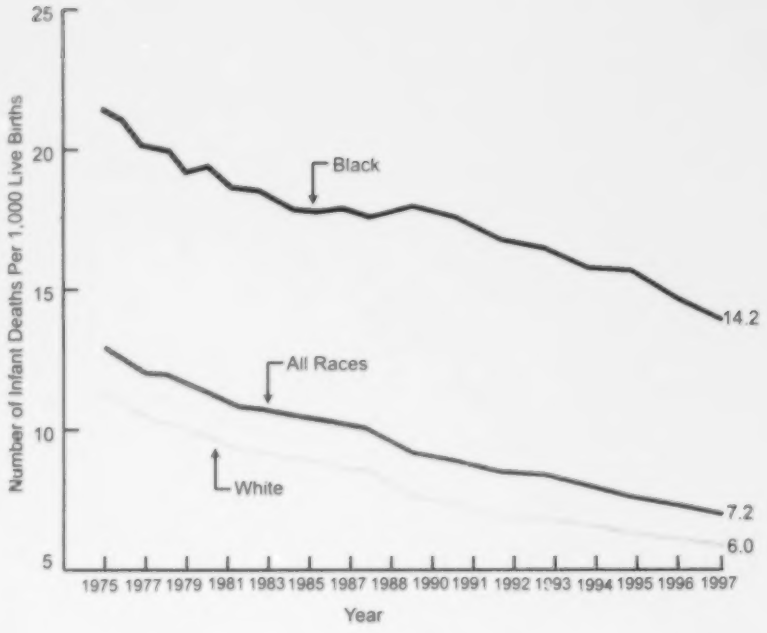
The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s.

The 1997 infant mortality rate for black infants was 2.4 times the rate for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between the black and white races has increased over time.

*Includes the ethnic classification of Hispanic.

U.S. INFANT MORTALITY RATES BY RACE OF MOTHER: 1975–1997

Source (U.S. National Center for Health Statistics)



NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1997, 18,524 infants younger than 28 days died, resulting in a neonatal mortality rate of 477.3 deaths per 100,000 live births. Both the overall mortality rate and rates by most leading causes of mortality were not statistically different from 1996 to 1997.

Disorders resulting from short gestation and low birth weight are the primary causes of neonatal mortality for blacks, while congenital anomalies are the leading causes for whites.

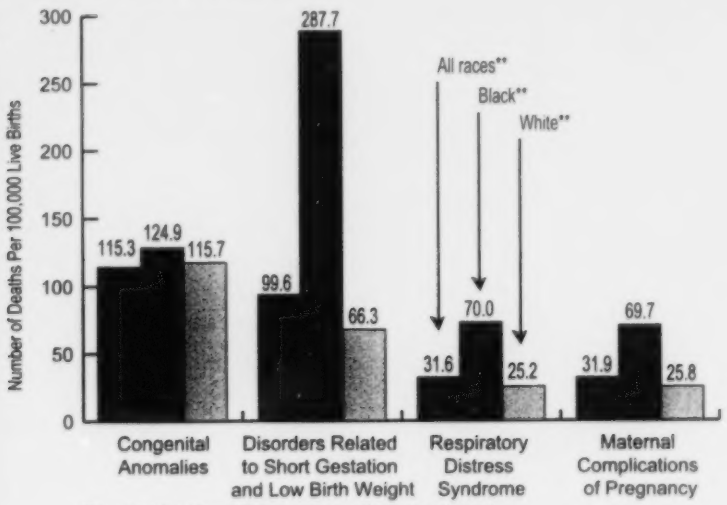
Postneonatal

In 1997, 9,521 infants 28 days to 11 months old died; the postneonatal mortality rate was 245.3 deaths per 100,000 live births, which was not substantially different from 1996.

The postneonatal mortality rate for blacks is at least two times that for whites for most of the leading causes of postneonatal mortality.

LEADING CAUSES OF NEONATAL* MORTALITY: 1997

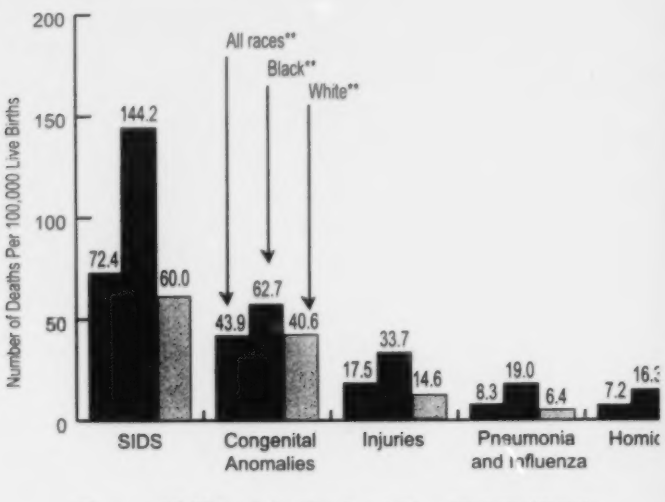
Source (IL3): National Center for Health Statistics



*Neonatal: less than 28 days old. **Includes Hispanic

LEADING CAUSES OF POSTNEONATAL* MORTALITY: 1997

Source (IL3): National Center for Health Statistics



*Postneonatal: 28 days to less than 1 year old. **Includes Hispanic

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed, and the maternal mortality rate was not statistically different in 1997 than in 1996.

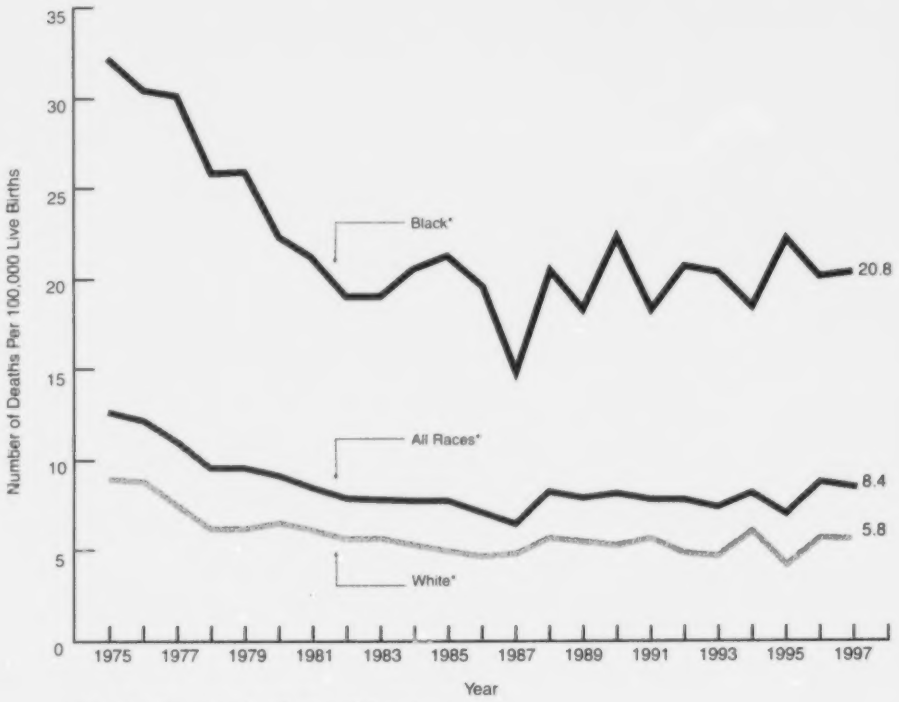
In 1997, there were 327 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

The maternal mortality rate for black women (20.8 per 100,000 live births) is more than three times the rate for white women (5.8 per 100,00 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35- to 39-years-old have approximately twice the risk of maternal death than those aged 20-24 years.

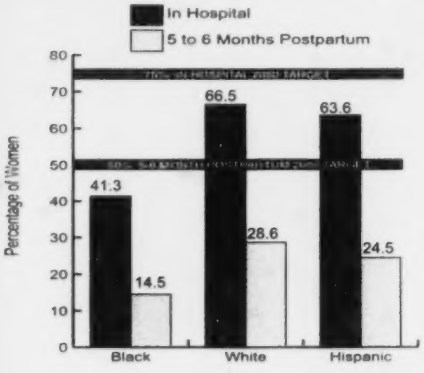
MATERNAL MORTALITY RATES BY RACE OF MOTHER: 1975–1997

Source (II.3): National Center for Health Statistics

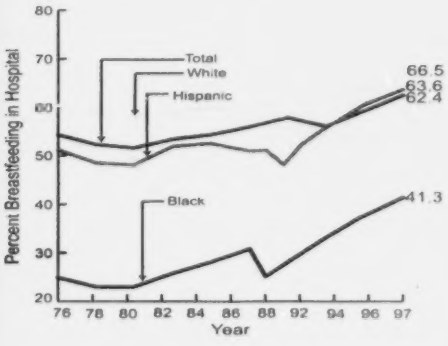


*Includes the ethnic classification of Hispanic

BREASTFEEDING BY RACE: 1997*
Source (II.4): Abbott Laboratories



BREASTFEEDING BY RACE: 1997
Source (II.4): Abbott Laboratories



INFANT FEEDING

Throughout the 1970's and early 1980's, the percentage of mothers who began breastfeeding in the hospital increased steadily to 61.9 percent, but then gradually declined to 51.5 percent by 1990. Since 1991, an increase in rates for black, Hispanic, and white women has produced a rate of 62.4 percent in 1997, the highest in recent years.

Since 1990, rates of breastfeeding immediately after delivery grew the most among groups of mothers that have traditionally been the least likely to breastfeed, such as black and Hispanic women. Over the past eight years, the rate of breastfeeding has increased 80 percent among black women and 33 percent among Hispanic mothers. These increases have contributed to a substantial reduction in the gap in breastfeeding rates between white and nonwhite women.

Breastfeeding rates for women of all races decrease substantially between delivery and 6 months postpartum, the breastfeeding period recommended as most critical for the infant's health by the Surgeon General of the United States. The percentage of women who report that they are still breastfeeding at 6 months postpartum in 1997 increased since 1996, but were only 28.6 percent, 24.5 percent, and 14.5 percent for white, Hispanic, and black women respectively. These rates represent a sharp decline from rates immediately after delivery of 37.9 percent among whites, 39.1 percent among Hispanics, and 26.8 percent among blacks.

Breastfeeding rates were highest among women over 35 years of age, college educated, not participating in the Women, Infants, and Children (WIC) dietary supplement program, and/or living in the western states. Women were also more likely to breastfeed their first child. Women least likely to breastfeed were younger than 20 years of age, not employed, low-income, black and/or living in the southeastern United States.

**Includes exclusive and supplemented breastfeeding.*

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CHILD MORTALITY

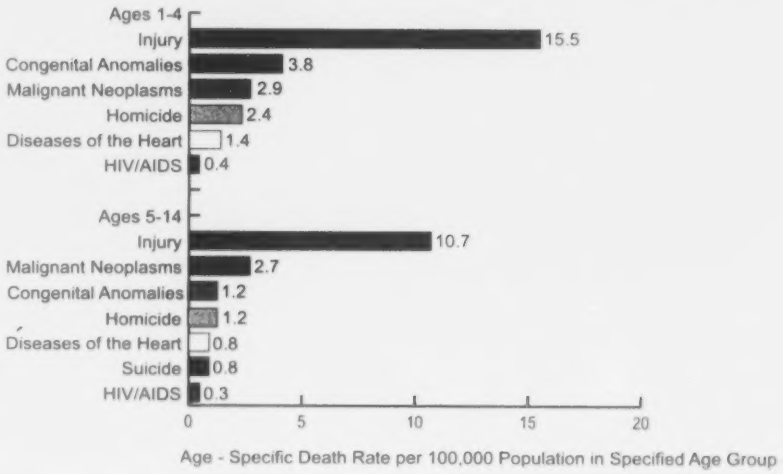
There were 13,562 deaths of children ages 1-14 in 1997. Injury, of any type, and regardless of intent, was the primary cause of death in that age group. Among 1-4 year old children, injuries accounted for 43.3 percent of all deaths, followed by deaths due to congenital anomalies (birth defects), malignant neoplasms (cancer), homicide, diseases of the heart, and HIV or AIDS.

Injuries comprised 51.4 percent of all deaths among 5- to 14-year-old children, followed by malignant neoplasms, homicide, congenital anomalies, diseases of the heart, suicide, and HIV or AIDS.

Childhood death rates have declined substantially over the past several decades. Death rates for children ages 1-4 years of age decreased 6.5 percent from 1996, while those aged 5-14 years decreased more than 4 percent.

LEADING CAUSES OF DEATH IN CHILDREN AGES 1-14: 1997

Source (IL3): National Center for Health Statistics



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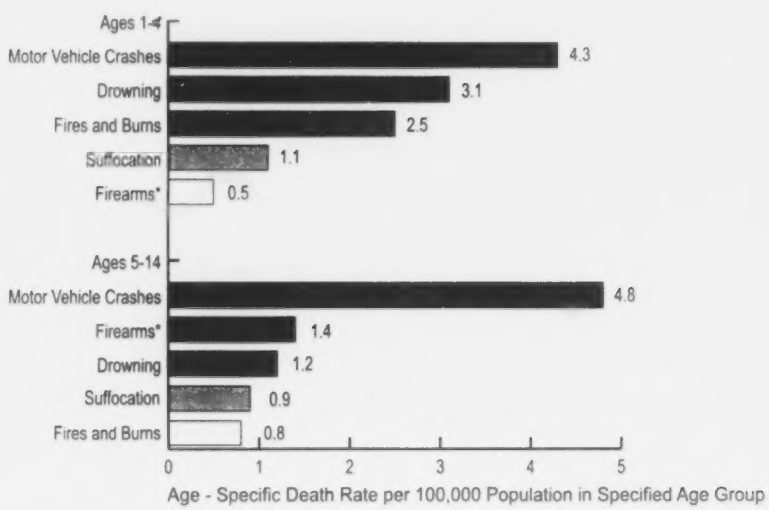
CHILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 1997

Source (H.3): National Center for Health Statistics



*Firearms-related deaths include homicides, suicides, and accidents.

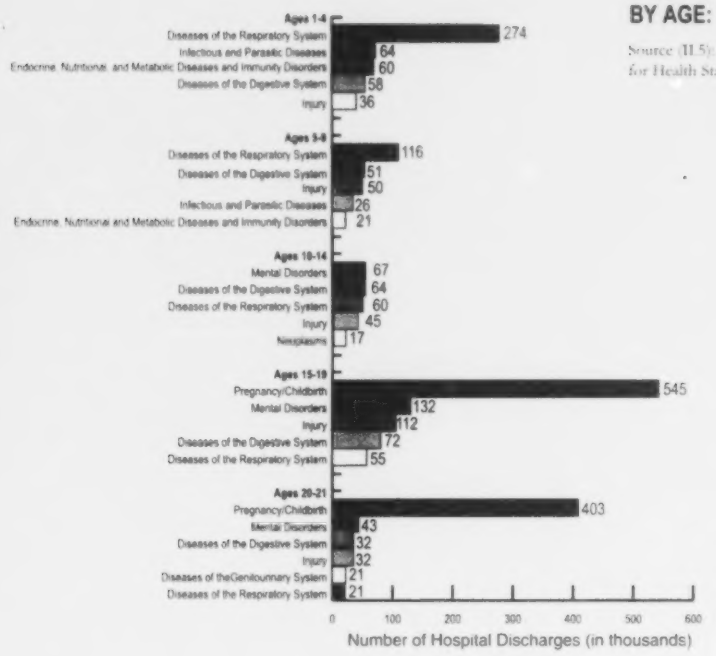
CHILDHOOD DEATHS DUE TO INJURY

In 1997, injuries caused the deaths of 2,383 1- to 4-year-old children and 4,150 5- to 14-year-old children.

Among 1- to 4-year-old children, motor vehicle crashes, drowning, and fire were the leading causes of injury death. Motor vehicle crashes were the leading cause of injury death among 5- to 14-year-old children, followed by firearm deaths. About 52 percent of firearm deaths among 5- to 14-year-old children were homicides.

MAJOR CAUSES OF HOSPITALIZATION BY AGE: 1997

Source (II.5): National Center for Health Statistics



HOSPITALIZATION

In 1997, there were 3.3 million hospital discharges of children 1 through 21 years old, or 4.0 discharges per 100 children that year.

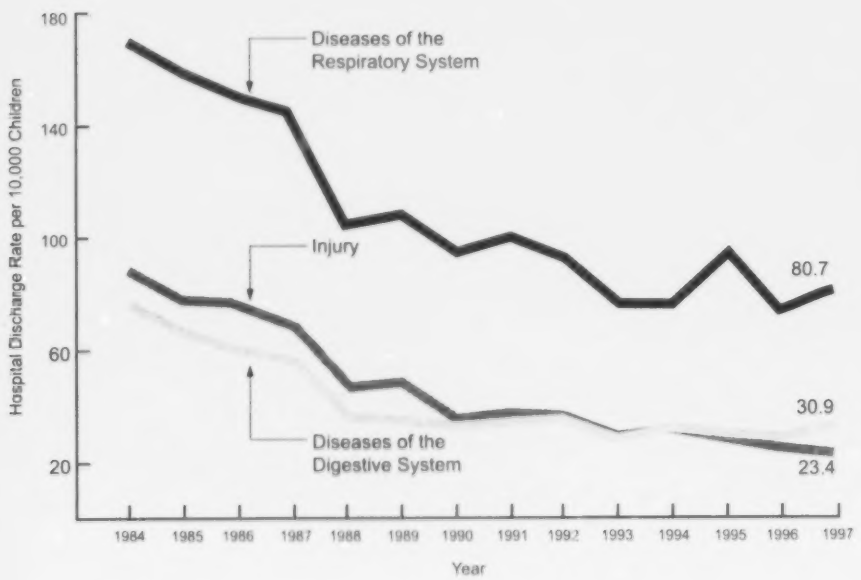
Diseases of the respiratory system were the major causes of hospitalization for children 1-9 years of age and accounted for 35 percent of their discharges.

Hospital discharge rates generally decrease until about age 10 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 8 percent of the hospital discharges of children 1-14 years old in 1997. Pregnancy and childbirth accounted for 69 percent of discharges of young women ages 15-21.

DISCHARGE RATE OF PATIENTS 1–14 YEARS OLD FOR SELECTED DIAGNOSES: 1984–1997

Source (II.5): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1984, there has been a 45 percent decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1984 and 1997, there was a 43 percent decline in the hospital discharge rate for diseases of the respiratory system in children in this age group.

Three diagnostic categories (respiratory diseases, injury, and digestive diseases) accounted for 49 percent of the discharges of children aged 1-14 years in 1997.

PEDIATRIC AIDS

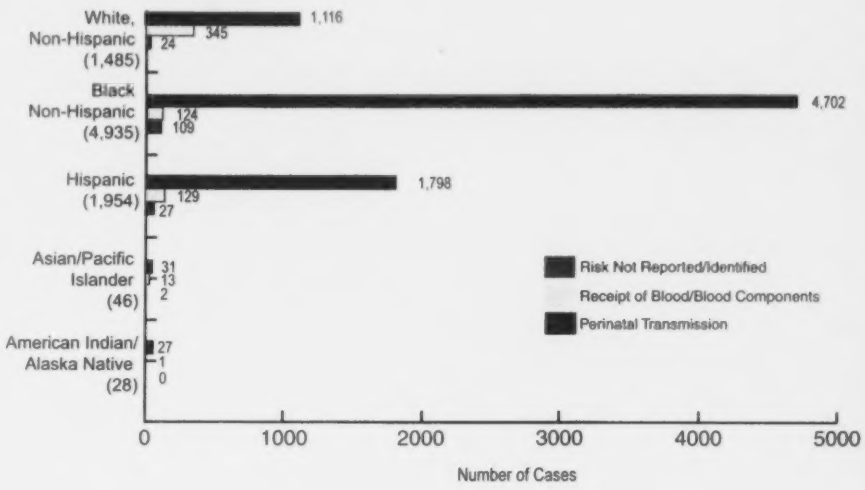
As of December 31, 1998, 8,461 cases of AIDS in children younger than 13 had been reported in the U.S.; this total includes 382 newly reported cases in 1998. Pediatric AIDS cases represented less than 1.2 percent of all cases reported to date.

The majority of pediatric AIDS cases result from transmission before or during birth (perinatal transmission). However, the number of new cases of pediatric AIDS due to perinatal transmission has declined by 54.2 percent since 1993. A major factor in this decline is the increasing use of zidovudine (ZDV) treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV-positive pregnant women, and in 1995, routine HIV counseling and voluntary testing for all pregnant women were recommended.

The number of pediatric AIDS cases ever reported in black, non-Hispanic children is more than three times that of white, non-Hispanic children and two and one-half times that of Hispanic children.

PEDIATRIC AIDS BY RACE/ETHNICITY AND EXPOSURE CATEGORY: 1981–1998

Source (II.6): Centers for Disease Control and Prevention



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CHILD ABUSE AND NEGLECT

In 1997, investigations by child protective services agencies in 44 states determined that approximately 984,000 children were victims of substantiated or indicated child abuse or neglect, equivalent to a rate of 13.9 per 1,000 children younger than 18 years of age. Seventy-five percent of the perpetrators of child maltreatment were the parents of the victims. Another 10 percent were other relatives, and 2 percent were persons in other caretaking roles (e.g., foster parents, facility staff, and child care providers).

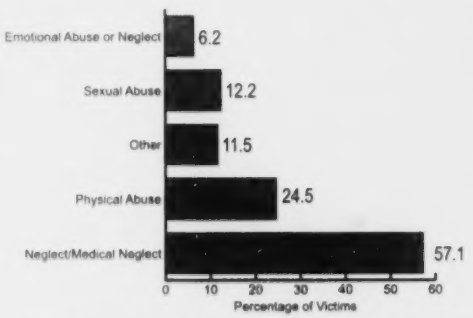
Approximately 25 percent of all victims were younger than 4 years old; more than half were 7 years of age or younger; about 27 percent were ages 8-12; and 19 percent were ages 13-17. Approximately 57 percent suffered neglect, 25 percent physical abuse, 12 percent sexual abuse, 6 percent emotional maltreatment, and 12 percent other forms of maltreatment. Some children suffered multiple types of maltreatment.

Forty-one states reported that a total of 967 children died from abuse or neglect. Available data suggest that more than three-quarters of children dying from abuse and neglect were under age 4.

The National Child Abuse and Neglect Data System (NCANDS) is the primary source of national information on abused and neglected children known to state child protective services agencies. In 1997, 45 state child protective services agencies received reports alleging the maltreatment of nearly 3 million children. Approximately half of the reports were from community professionals, and one-quarter of the reports came from members of the general public (such as friends, relatives, or neighbors of the reported children).

PERCENTAGE OF CHILD ABUSE AND NEGLECT VICTIMS BY TYPE OF MALTREATMENT: 1997

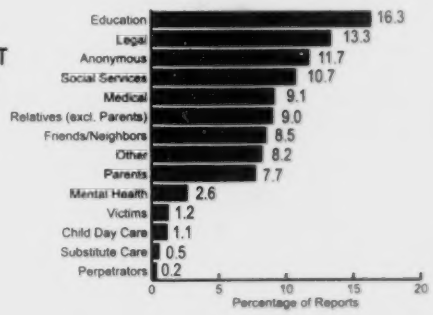
Source (II.7): U.S. Department of Health and Human Services



Note: Percentage totals more than 100% because some states report more than one type of maltreatment per victim. Includes 798,358 victims in 41 States.

SOURCES OF MALTREATMENT REPORTS: 1997

Source (II.7): U.S. Department of Health and Human Services



Note: 1,450,399 reports from 42 States.

ADOLESCENTS

In 1998, individuals aged 13-19 accounted for roughly 11 percent of the U.S. population. For the most part, adolescents are a healthy population. However, adolescence is a time of physical and emotional growth and exploration. Many adolescents engage in risk-taking behaviors that may result in acute illnesses and infections, poor long-term health outcomes, and even disability and death. For example, adolescents may experiment with cigarettes and drugs, are involved in motor vehicle crashes, and engage in unprotected sex. This section features many health status indicators related to cigarette smoking, use of illicit drugs, adolescent mortality, injury, sexual intercourse, sexually transmitted diseases, pregnancy, and abortion. Many of these data are presented by age, gender, race, and ethnicity.

Adolescence is also a period during which many lifelong health habits are formed, such as diet, exercise, and the use of the health care services. National data related to physical activity and overweight are also explored in this section. Traditionally, teenagers do not use health services in great numbers, particularly preventive health services. The following section addresses health risks faced by adolescents.

PHYSICAL ACTIVITY AND OVERWEIGHT

Results of the 1997 Youth Risk Behavior Surveillance System Survey (YRBSS) show that nearly two thirds of students participate regularly in vigorous physical activity and one fifth regularly participate in moderate physical activity. Furthermore, 51 percent of the students do regular strengthening exercises. Nationwide, nearly 50 percent of students were enrolled in a physical education class, but students in 9th grade were significantly more likely to be enrolled than students in 11th and 12th grades.

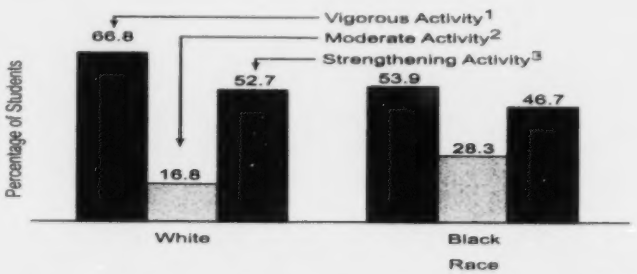
The 1997 YRBSS revealed that over 25 percent of 9th through 12th grade students thought that they were overweight, and nearly 40 percent were attempting weight loss. Female students were more than twice as likely as male students to be attempting weight loss (60 percent versus 23 percent). Nearly one third of all students had dieted either to lose weight or to keep from gaining weight during the 30 days preceding the survey. Over 50 percent of students had exercised either to lose weight or to keep from gaining weight.

1 Activities that caused sweating and hard breathing for at least 20 minutes >3 of the preceding 7 days.

2 Walked or bicycled for at least 30 minutes on >5 of the 7 days preceding the survey.

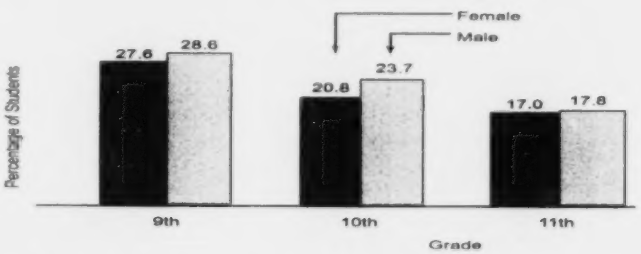
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 1997

Source (II.8): Centers for Disease Control and Prevention.



PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN MODERATE PHYSICAL ACTIVITY, BY GRADE: 1997

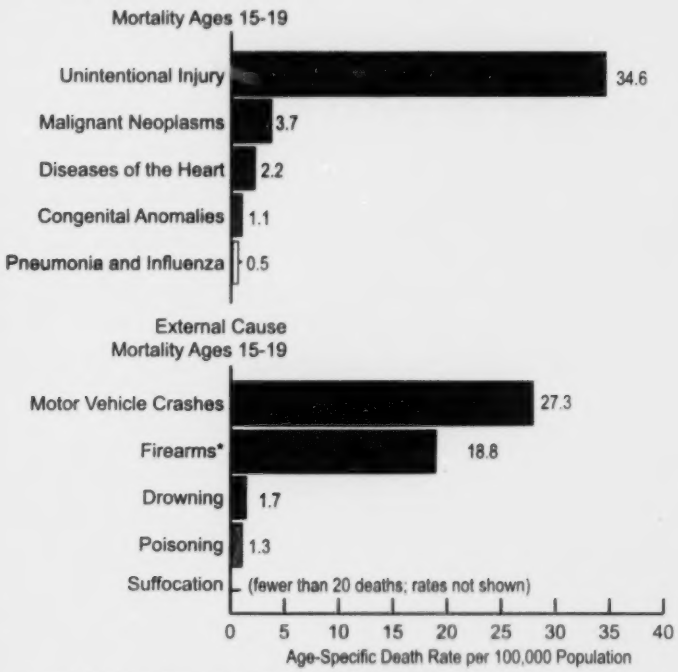
Source (II.8): Centers for Disease Control and Prevention.



3 Such as push-ups, sit-ups, or weight lifting on >3 of the 7 days preceding the survey.

LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15–19: 1997

Source (II.3): National Center for Health Statistics



*Firearms-related deaths include homicides, suicides, and accidents.

ADOLESCENT MORTALITY

In 1997, there were 14,272 deaths of adolescents aged 15-19 years. In that age group, injury was the leading cause of death. The 6,603 injury deaths accounted for 46 percent of all deaths among 15- to 19-year-olds in 1997. Malignant neoplasms (cancer) were the next leading cause of death, accounting for 4.9 percent of all deaths among 15- to 19-year-olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15- to 19-year-olds in the mid to late 1980s. The death rate among that age group has decreased 16 percent since 1993.

Motor vehicle crashes were the leading cause of injury mortality among 15- to 19-year-olds in 1997, accounting for approximately 79 percent of all injury deaths among teenagers. The next two leading causes of injury death—drowning and poisoning—each accounted for 4.8 percent to 5 percent of all injury deaths among 15- to 19-year-olds.

ADOLESCENT DEATHS DUE TO INJURY

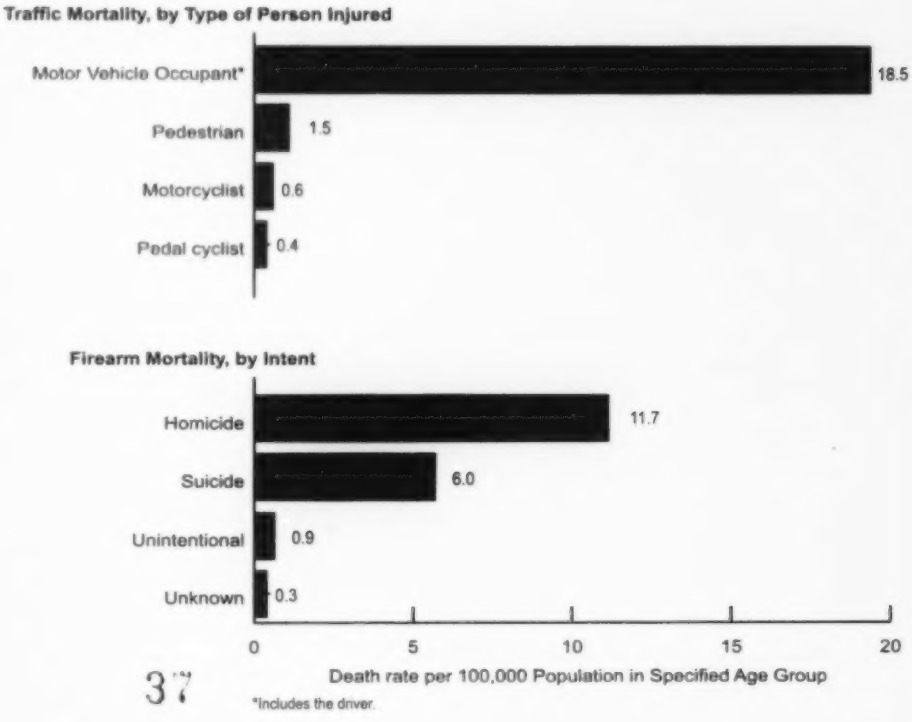
In 1997, motor vehicle crashes caused the death of 5,213 15- to 19-year-olds. About 68 percent of those killed were in motor vehicles, either as passengers or the driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among teenagers.

Results of CDC's 1997 Youth Risk Behavior Surveillance System (YRBSS) survey revealed that in the 30 days preceding the survey, 19.3 percent of respondents had rarely or never used a safety belt, and 36.6 percent had ridden with a driver who had been drinking alcohol.

In 1997, 3,593 15- to 19-year-olds were killed by firearms in the U.S. Homicide accounted for 62 percent of firearm deaths among teenagers, 31.6 percent were suicide and 4.6 percent were considered to be unintentional.

MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15–19: 1997

Source (II.3): National Center for Health Statistics



SEXUAL INTERCOURSE

Among high school students in the U.S., the percentage of students in 9th through 12th grades reporting ever having sexual intercourse has declined slightly in recent years. However, black students were still significantly more likely than white and Hispanic students to have had sexual intercourse.

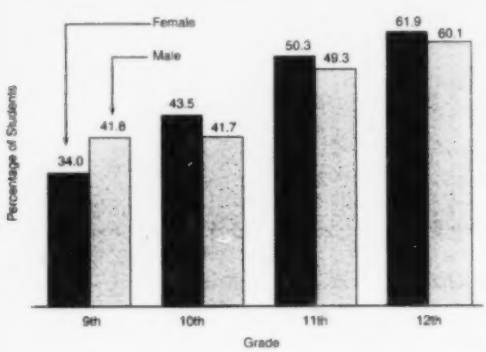
Approximately 46 percent of students in the 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among both females (22.4 percent to 49.5 percent) and males (25.9 percent to 43.1 percent). Overall, male students were significantly more likely than female students (17.6 percent versus 14.1 percent) to have had four or more sex partners during their lifetime.

CONDOM USE

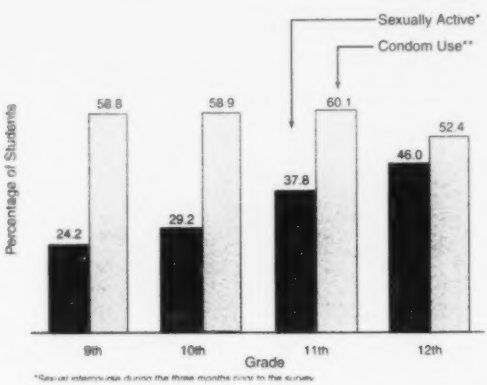
In 1997, more than half (56.8 percent) of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used.

Sexual activity increased by grade for all students; however, condom use was less likely among 12th graders.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 1997
Source (II.8): Centers for Disease Control and Prevention

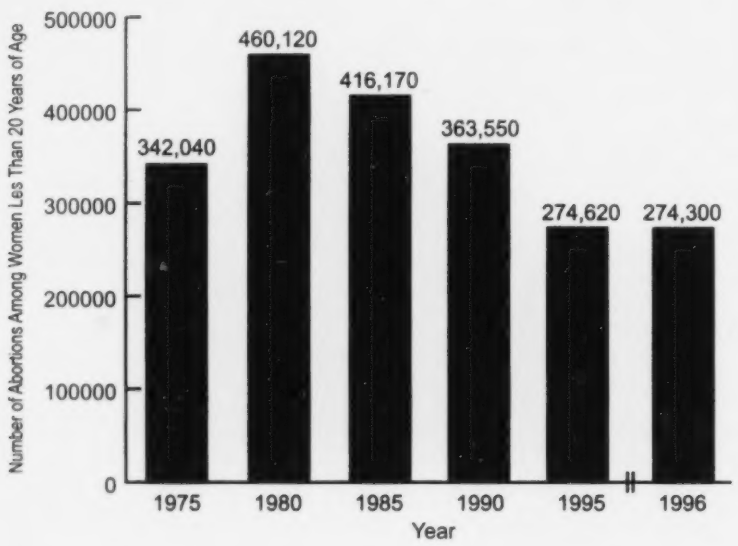


SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS: 1997
Source (II.8): Centers for Disease Control and Prevention



ABORTIONS AMONG WOMEN UNDER 20 YEARS OF AGE: 1976–1996

Source (II.9): The Alan Guttmacher Institute



ABORTION AMONG ADOLESCENTS

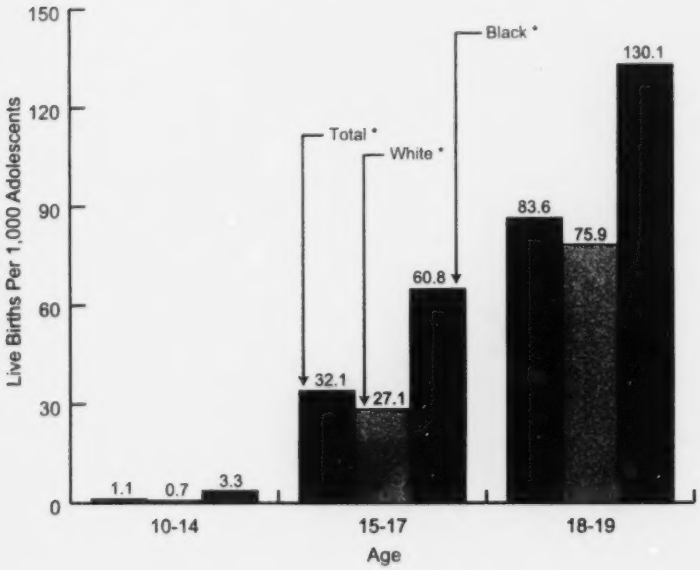
In 1996, there were 905,000 pregnancies among women younger than 20 years of age. Pregnancy outcomes included 502,725 live births (55.5 percent) and 274,300 legal abortions (30.3 percent).

Although the number of abortions among females younger than 20 increased sharply from 1975 to 1980, the rate has decreased steadily from 1980-1996. While the number of abortions decreased by 10 percent from 1980 to 1985, it decreased by 24.5 percent from 1990 to 1996.

Researchers consistently find four broad factors that predict sexual intercourse at an early age, adolescent pregnancy, and nonmarital childbearing among teenagers: school failure, early behavior problems, poverty, and family problems/family dysfunction.

LIVE BIRTHS AMONG ADOLESCENTS, BY AGE AND RACE OF MOTHER: 1997

Source (II.10): National Center for Health Statistics



ADOLESCENT CHILDBEARING

In 1997, the live birth rate per 1,000 adolescent females was 1.1 for ages 10-14, 32.1 for ages 15-17, and 83.6 for those 18- to 19-years-old. The birth rates among 15- to 19-year-olds in 1997 represent an overall decrease of 16 percent between 1991 and 1997.

In 1997, there were 338,272 live births among white females ages 15-19 and 128,539 births among black teenagers. The birth rates were 46.3, 88.2, and 97.4 for white, black, and Hispanic teenagers respectively. Although the birth rates for black teenagers remains relatively high in comparison to the rate for white teens, the largest decline in birth rates by race between 1991 and 1997 was among black teens. The overall rate of adolescent childbearing among black teens 15- to 19-years-old fell 23.6 percent to 88.2 per 1,000, the lowest rate ever recorded. The birth rate among Hispanic teens fell the least, 8.7 percent, leaving Hispanic teenagers with the highest adolescent birth rate in the three groups.

**Includes the ethnic classification of Hispanic.*

SEXUALLY TRANSMITTED DISEASES

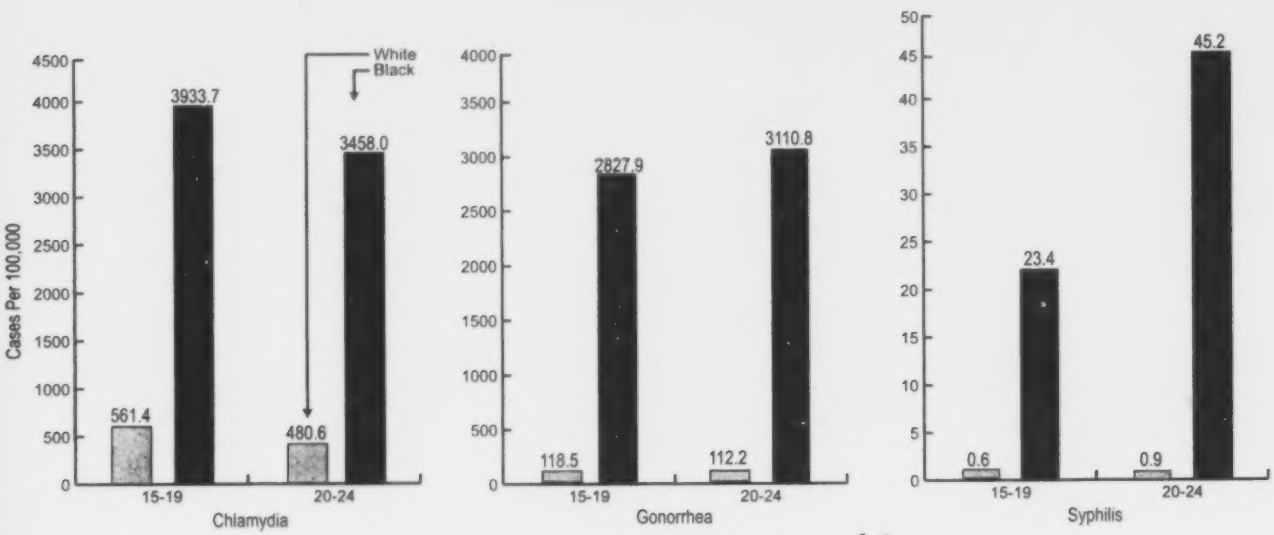
Rates of reportable sexually transmitted diseases (STDs) are particularly high among adolescents (ages 15-19) and young adults (ages 20-24). In these age groups, reported rates of chlamydia, gonorrhea, and syphilis are much higher among black non-Hispanic youth than white non-Hispanics.

The most common STD in adolescents and young adults in 1997 was chlamydia, a bacterial infection, with 1,126 cases per 100,000 teens ages 15-19, followed by gonorrhea, with 530 cases per 100,000. Syphilis is much rarer in teens, with only 4.2 cases per 100,000 reported in 1997.

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV, and untreated STDs can lead to pelvic inflammatory disease and infertility in women.

RATES OF SEXUALLY TRANSMITTED DISEASES PER 100,000 ADOLESCENTS BY AGE AND RACE: 1997

Source (II.11): Centers for Disease Control and Prevention



ADOLESCENT AIDS

As of December 31, 1998, 3,423 cases of AIDS had been reported in adolescents aged 13-19 years. This total includes 297 newly reported cases in 1998.

Forty-eight percent of adolescent AIDS cases were among black non-Hispanics. Thirty-four percent of blacks aged 13-19 were exposed to HIV through heterosexual contact and 25 percent were exposed through male-to-male sexual contact.

Whites comprised 31 percent of the AIDS cases among adolescents. Of these, 59 percent were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions (however, only 9.4 percent of newly-reported cases in 1998 involved this source of transmission). Nineteen percent of whites aged 13-19 years were exposed to HIV through male-to-male sexual contact.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV infected persons with CD4 counts of less than or equal to 200 cells/ul., or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

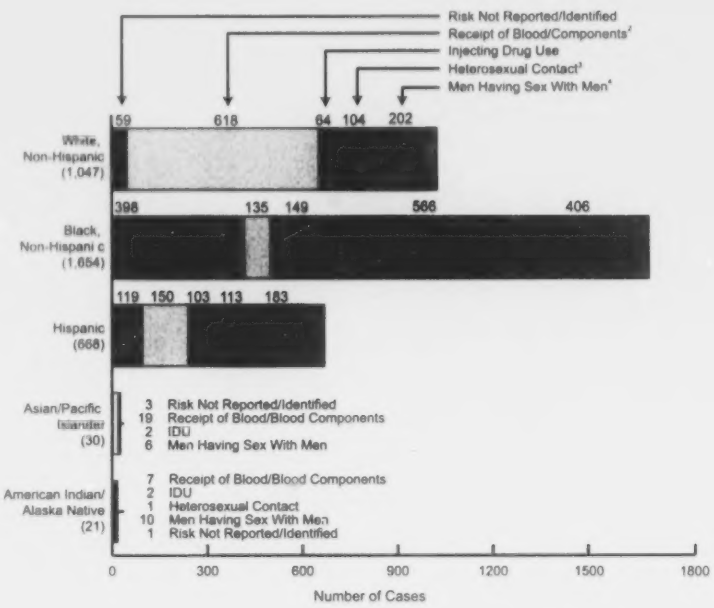
2 Receipt of Blood/Blood components:
Received clotting factor for hemophilia coagulation disorder
Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

ADOLESCENT AIDS CASES, BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 13–19: 1981–1998

Source (II.12): Centers for Disease Control and Prevention



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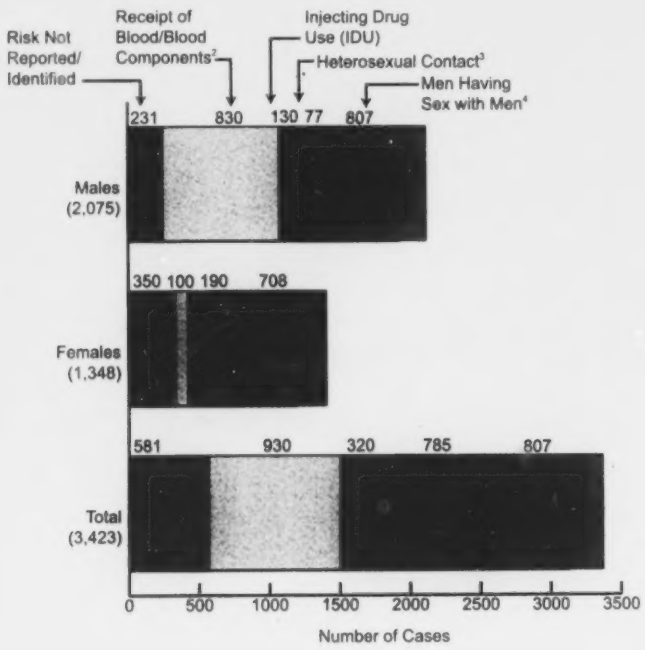
ADOLESCENT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 13–19: 1981–1998

Source (IL12): Centers for Disease Control and Prevention



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ADOLESCENT AIDS

Males comprise 61 percent of the 3,423 AIDS cases ever reported among adolescents aged 13-19 years; however, males aged 13-19 represent 50 percent of the 297 AIDS cases reported in 1998. Nearly one third of these new cases were transmitted by men having sex with men. The risk category was not reported or identified for 36 percent of adolescent male AIDS cases reported in 1998.

Thirty-nine percent of adolescent AIDS cases ever reported were among females. However, the proportion of AIDS cases that are new in adolescent females is increasing. In 1998, females aged 13-19 accounted for 50 percent of reported AIDS cases. Of these, 53 percent acquired HIV infection through heterosexual contact, 19 percent had sex partners who were injecting drug users, and 14 percent were injecting drug users themselves.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/ uL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/ Blood components:

- *Received clotting factor for hemophilia coagulation disorder*
- *Received blood transfusions, blood components, or tissue*

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS

As of December 31, 1998, 24,437 cases of AIDS were reported in young adults aged 20-24 years. This total includes 1,501 newly reported cases in 1998. The number of newly reported cases decreased by nearly 19 percent from 1997 to 1998.

Across all racial/ethnic groups, "men who have sex with men" is the major exposure category associated with AIDS cases in young adults. Young adult women (27 percent of known AIDS cases in this age group) are exposed to HIV primarily through injecting drug use (28 percent) or through sex with an injecting drug user (22 percent).

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

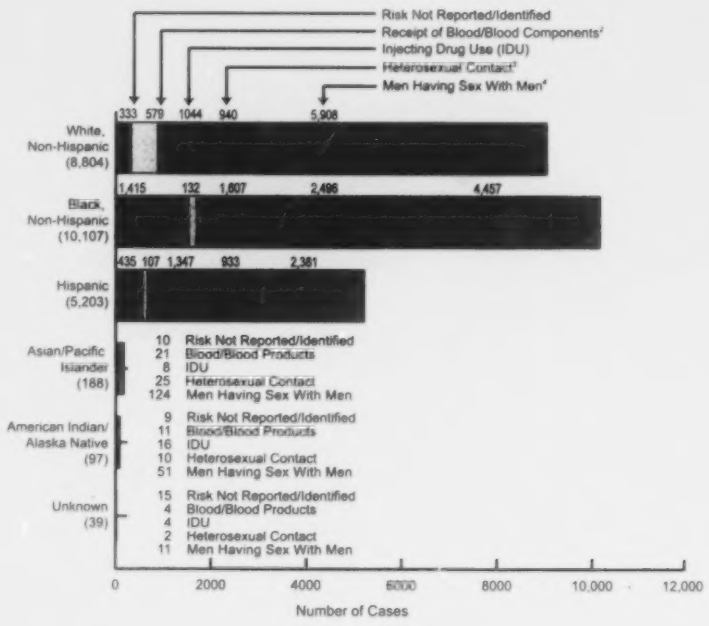
2 Receipt of Blood/Blood components:
Received clotting factor for hemophilia coagulation disorder
Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 20–24: 1981–1998

Source (II.12): Centers for Disease Control and Prevention



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VIOLENCE

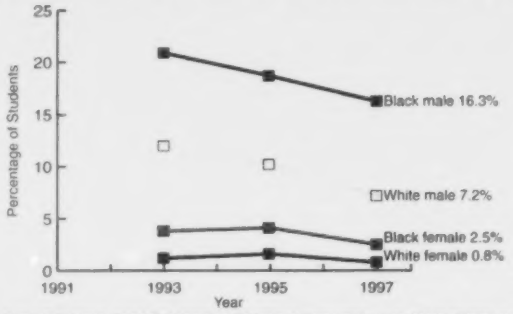
Violence among adolescents has been a longstanding problem in the United States. Firearms (including homicides, suicides, and accidents) were the second leading external cause of death in adolescents ages 15-19 in 1997.

Results of the Youth Risk Behavior Surveillance System (YRBSS) show that in 1997, 18.3 percent of high school students had carried a weapon, such as a gun, knife, or club on one or more days in the last 30 days; nearly 6 percent of students had carried a gun. Boys (27.7 percent) were almost four times as likely as girls (7.0 percent) to carry a weapon. The percentage of high school students who carry weapons has decreased 17 percent since 1993.

Some high school students also reported taking weapons to school. In 1997, 8.5 percent of students had carried a weapon on school property in the last thirty days—a decrease of 28 percent since 1993. However, despite the fact that the percentage of high school students who carry weapons on school property has declined in recent years, the percentage of students who reported being threatened or injured with a weapon on school property in 1997 (7.4 percent) has remained about the same since 1993. In addition, four percent of high school students of both sexes felt too unsafe to go to school. Boys, younger students, and Black and Hispanic students expressed the most concern for their safety.

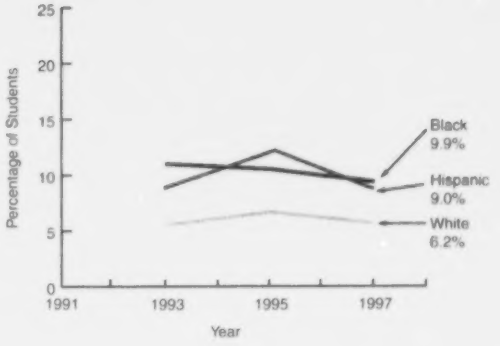
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO CARRIED A GUN IN THE PAST 30 DAYS, BY SEX AND RACE, 1991-1997

Source (IL8): Centers for Disease Control and Prevention



PERCENTAGE OF HIGH SCHOOL STUDENTS WHO WERE THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY, BY RACE, 1991-1997

Source (IL8): Centers for Disease Control and Prevention



CIGARETTE SMOKING

The University of Michigan's Institute for Social Research found that cigarette smoking among youth in most age and demographic groups decreased slightly between 1997 and 1998. Thirty-five percent of high school seniors reported that they had smoked cigarettes in the 30 days prior to the survey, a 3.8 percent decrease from 1997.

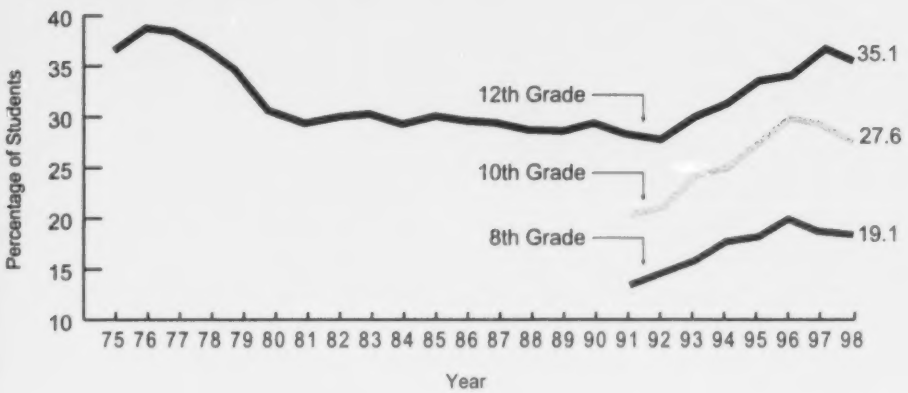
Smoking among adolescents will have severe, lifelong consequences for this generation, because a large proportion of those who initiate smoking in adolescence will continue to smoke for the rest of their lives.

However, since 1991, substantial increases in smoking have occurred in virtually every sociodemographic group; among boys and girls, among those bound for college and those not, among respondents in all regions of the country and in rural and urban areas, and among whites, blacks, and Hispanics. The rate of smoking among 8th-grade girls increased 50 percent over this period, and the percentage of black 8th- and 10th-graders who smoked doubled.

There are, however, some subgroup differences in smoking rates: respondents with no future college plans were more likely to smoke than those who had such plans; 12th grade students were most likely to smoke; and black youth remain substantially less likely to smoke than white youth.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF CIGARETTE SMOKING FOR 8TH-, 10TH-, AND 12TH-GRADERS: 1975–1998

Source (IL13): The Monitoring the Future Study, University of Michigan



SUBSTANCE ABUSE

Trends in Thirty-Day Prevalence

Results of the Substance Abuse and Mental Health Services Administration's 1998 National Household Survey on Drug Abuse* show that the percentage of adolescence ages 12-17 who reported using illicit drugs, specifically alcohol, marijuana, and cocaine, in the month prior to the survey decreased significantly from 1997 to 1998. The rate of adolescent use of any illicit drugs declined from 11.4 percent in 1997 to 9.9 percent in 1998.

The proportion of adolescents reporting using marijuana in the past month decreased from 9.4 percent in 1997 to 8.3 percent in 1998, although this drop does not represent a statistically significant change. Marijuana use among adolescents has declined substantially from the highest level recorded in 1979 (14.2 percent); however, use has more than doubled from the lowest recorded rate of 3.4 percent in 1992.

There was a statistically significant decrease in the current use of inhalants among youth age 12 to 17, from 2.0 percent in 1997 to 1.1 percent in 1998. There was no significant change in the reported use of alcohol, cocaine, heroin, or hallucinogens from 1997 to 1998. Nineteen percent of adolescents age 12-17 are current drinkers. Of these, 7.7 percent reported binge drinking, and 2.9 percent reported heavy alcohol use.

** The National Household Survey on Drug Abuse is based on a representative sample of the U.S. population aged 12 and older, including persons living in households and in some group quarters such as dormitories and homeless shelters.*

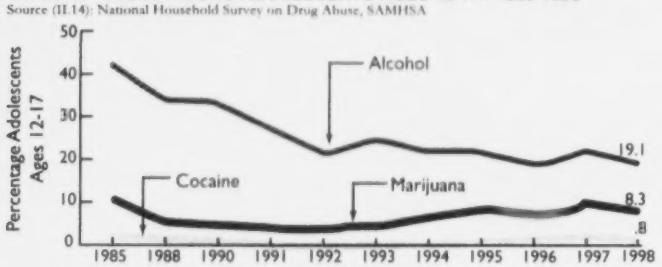
Perception of Risk and Access to Drugs

In 1998, 30.8 percent of adolescents perceived smoking marijuana to be risky, while 54.3 percent perceived cocaine use to be risky. There was no change in the perceived risk of marijuana and cocaine use from 1997 to 1998.

Fifty-six percent of the adolescents surveyed in 1998 reported that marijuana was easy to obtain, 30 percent said that cocaine was easy to obtain, and 21 percent said heroin was easy to obtain. Approximately 14 percent of respondents reported being approached by someone selling drugs in the month prior to the survey. None of these access measures changed significantly from 1997 to 1998.

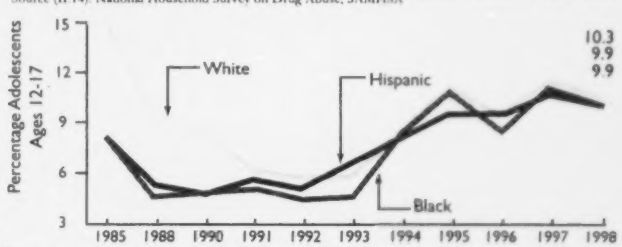
LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF VARIOUS TYPES OF DRUGS AMONG ADOLESCENTS AGES 12-17: 1985-1998

Source (II.14): National Household Survey on Drug Abuse, SAMHSA



LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF ANY ILLICIT DRUG AMONG ADOLESCENTS AGES 12-17, BY RACE/ETHNICITY: 1985-1998**

Source (II.14): National Household Survey on Drug Abuse, SAMHSA



*** Illicit drugs include marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP and LSD), heroin, or any prescription-type psychotherapeutic used non-medically.*

HEALTH SERVICES AND UTILIZATION

The availability of, and access to, quality health care directly affect the health of mothers and children, especially those at high risk due to chronic medical conditions or low socio-economic status. As more mothers and children become enrolled in Medicaid managed care, monitoring quality assurance has become, and will continue to be, increasingly important.

Nearly every state has begun to implement a Child Health Insurance Program, using new Federal funds that became available for the first time in 1998. This program will help to provide coverage to the approximately 10 million uninsured children in the U.S. An estimated 3 million of those children are eligible for Medicaid, but are not enrolled. Outreach and consumer education are therefore key components of the expansion of health insurance coverage for children.

The following section presents data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are presented by age, ethnicity, and income.

HEALTH CARE FINANCING

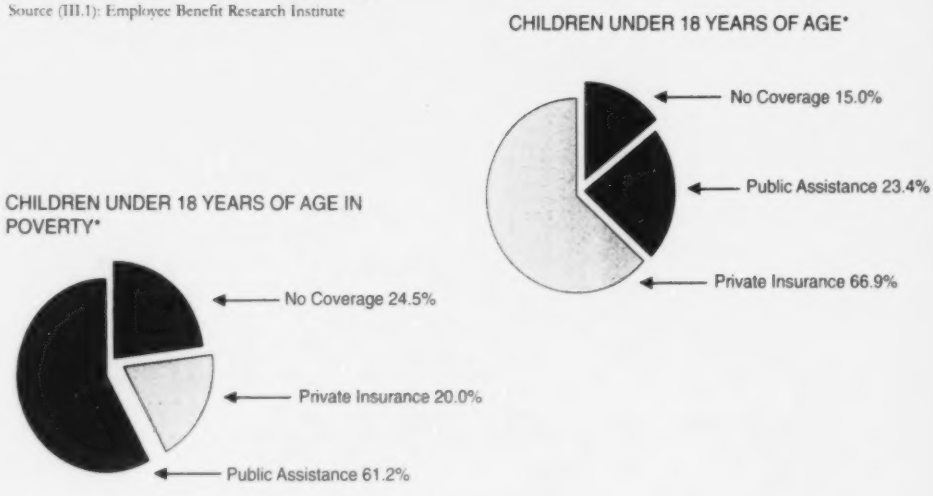
A 1998 report from the Employee Benefit Research Institute indicated that 15 percent, or 10.7 million children younger than 18 years of age, had no insurance coverage in 1997.

Of those children with insurance, 23.4 percent were publicly insured, primarily through Medicaid, and 66.9 percent were covered by private insurance. Most privately insured children (89.2 percent) received insurance through their parents' employer, but such coverage, when available, was increasingly expensive and required parental copayments.

Of children younger than 18 whose families lived in poverty, 61.2 percent were publicly insured and 20 percent had private coverage. However, 24.5 percent of children in poverty had no health coverage in 1997. An estimated 85.3 percent of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year. In response to the growing number of uninsured children, Congress passed the Balanced Budget Act of 1997, which created a new source of health care coverage for low-income children called The Children's Health Insurance Program (CHIP).

HEALTH INSURANCE COVERAGE: 1997

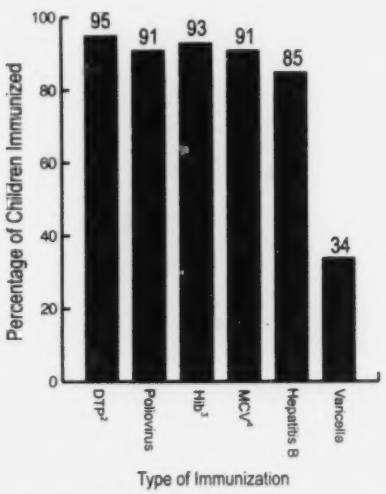
Source (III.1): Employee Benefit Research Institute


CHILDREN UNDER 18 YEARS OF AGE*
No Coverage 15.0%
Public Assistance 23.4%
Private Insurance 66.9%
CHILDREN UNDER 18 YEARS OF AGE IN POVERTY*
No Coverage 24.5%
Private Insurance 20.0%
Public Assistance 61.2%

**Details may add to more than 100% because individuals may receive coverage from more than one source.*

VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19–35 MONTHS BY SELECTED VACCINES: 1997-1998[1]

Source (III.2): Centers for Disease Control and Prevention



1. *Data are from July 1997 through June 1998.*
2. *DTP: Diptheria and Tetanus toxoids and pertussis vaccine, ≥ 3 doses.*
3. *Hib: Haemophilus influenzae type b ≥ 3 doses.*
4. *Includes any measles-containing vaccine, ≥ 1 dose.*

VACCINATION COVERAGE LEVELS

The Year 2000 objective for the complete series of routinely recommended childhood vaccinations is immunization of at least 90 percent of two-year-olds with the full series of vaccines. Data released from CDC's 1997-1998 National Immunization Survey revealed the highest immunization coverage ever recorded. In fact, all of the Childhood Immunization Initiative goals for 1996 were either met or exceeded. The greatest progress was seen in the rate of hepatitis B vaccination among children aged 19-35 months, which showed a 25 percent increase, from 68 percent to 85 percent, between 1995 and June 1998.

However, approximately 1 million children still need one or more of the recommended doses of a series vaccine to be fully protected. Coverage in state and urban areas varies, and therefore has not reached the national coverage level in some states and cities.

In January 1999, CDC published an updated childhood immunization schedule (see facing page). An additional vaccination recommendation was issued by CDC in early 1996: a new FDA-approved varicella (chicken pox) vaccine. By June 1998, approximately 34 percent of children aged 19-35 months had received this vaccine.

A new vaccine to protect children from rotavirus, the most common cause of severe diarrhea, was licensed in August 1998. Roughly 1.5 million doses of the new rotavirus vaccine were administered between August 31, 1998 and June 1, 1999. Due to reports of bowel obstructions in some infants, the CDC recommends that the use of the vaccine be postponed until November 1999 at which time they will have collected additional information about the relationship between the vaccine and reports of bowel obstruction.

The recent licensure of combination and single antigen vaccines will further challenge the vaccine delivery system. To maintain high coverage levels among children in the population, additional components of the system need to be developed. These include: 1) linkages between each child and an accountable primary care provider; 2) computerized vaccination registries including both public and private providers; 3) means for ensuring financial access to vaccines; and 4) mechanisms for educating parents about the importance of vaccines and educating providers about changes in recommendations.

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, JANUARY–DECEMBER 1999*

Source (III.3): Centers for Disease Control and Prevention

VACCINE / AGE	Routinely recommended age for vaccination										
	Birth	1 mo	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	4-6 yrs.	11-12 yrs.	14-16 yrs.
Hepatitis B[1]		Hep B									
			Hep B				Hep B			Hep B	
Diphtheria Tetanus Pertussis[2]			DTaP	DTaP	DTaP			DTaP	DTaP		Td
H. influenzae type b[3]			Hib	Hib	Hib		Hib				
Poliovirus[4]			IPV	IPV			Polio		Polio		
Rotavirus[5]			*Rv*	*Rv*	*Rv*						
Measles, Mumps, Rubella[6]							MMR		MMR	MMR	
Varicella[7]								Var		Var	

Shaded bar indicates acceptable age range; oval indicates vaccines to be assessed and administered during early adolescent visit if necessary. The dark shaded bar on the Rotovirus vaccine indicates that the addition of this new vaccine into clinical practice may require additional time and resources from health care providers.

* *This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Any dose not given at the recommended age should be given as a "catch-up" vaccination at any subsequent visit when indicated and feasible. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.*

[1] ***Infants born to hepatitis B surface antigen (HBsAg)-negative mothers*** *should receive the second dose of hepatitis B (Hep B) vaccine at least 1 month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before age 6 months.* ***Infants born to mothers HBsAg–positive mothers*** *should receive Hep B vaccine and 0.5 ml hepatitis B immune globulin (HBIG) within 12 hours of birth at separate injection sites. The second dose is recommended at age 1–2 months and the third dose at age 6 months.* ***Infants born to mothers whose HBsAg status is unknown*** *should receive Hep B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). All children and adolescents (through age 18 years) who have not been vaccinated against hepatitis B may begin the series during any visit. Special efforts should be made to vaccinate children who were born in or whose parents were born in areas of the world where hepatitis B virus infection is moderately or highly endemic.*

[2] *Diphtheria and tetanus toxoids and acellular pertussis vaccine (DtaP) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received one or more doses of whole-cell diphtheria and tetanus toxoids and pertussis vaccine (DTP). Whole-cell DTP is an acceptable alternative to DTaP. The fourth dose (DtaP or DTP) may be administered as early as 12 mos, provided 6 mos has elapsed since the 3rd dose and the child is unlikely to return at age 15–18 months. Tetanus and diphtheria toxoids (Td) is recommended at 11–12 years if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.*

[3] *Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 mos and 4 mos, a dose at age 6 mos is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2,4, or 6 months unless approved by the Food and Drug Administration for these ages.*

[4] *Two poliovirus vaccines are licensed in the United States; inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The ACIP, AAFP and AAP recommended that the first two doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of two doses of IPV administered at ages 2 and 4 mos followed by a dose of OPV at age 12-18 mos and at age 4-6 years. Use of IPV for all doses also is acceptable and is recommended for immunocompromised persons and their household contacts. OPV is no longer recommended for the first two doses of the schedule and is acceptable only for special circumstances (e.g., children of parents who do not accept the recommended number of injections, late initiation of vaccination that would require an unacceptable number of injections, and imminent travel to areas where poliomyelitis is endemic). OPV remains the vaccine of choice for mass vaccination campaigns to control outbreaks of wild poliovirus.*

[5] *The first dose of Rv vaccine should not be administered before age 6 weeks, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at age 7 months, and all doses should be completed by the first birthday. The AAFP opinion is that the decision to use rotavirus (Rv) vaccine should be made by the parent or guardian in consultation with the physician or other health-care provider.*

[6] *The second dose of measles, mumps, rubella vaccine (MMR) is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks has elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule no later than the routine visit to a health care provider at age 11–12 years.*

[7] *Varicella vaccine (Var) is recommended at any visit after the first birthday for susceptible children (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider] and who have not been vaccinated). Susceptible persons aged ≥13 years should receive 2 doses given at least 4 weeks apart.*

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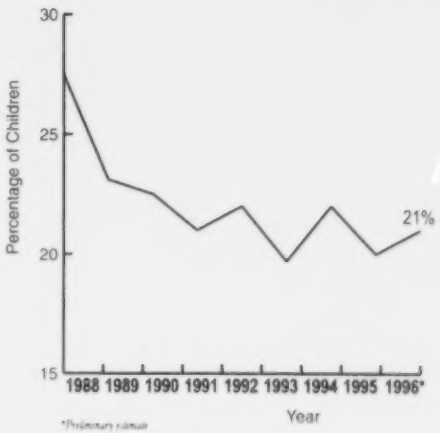
DENTAL SCREENING

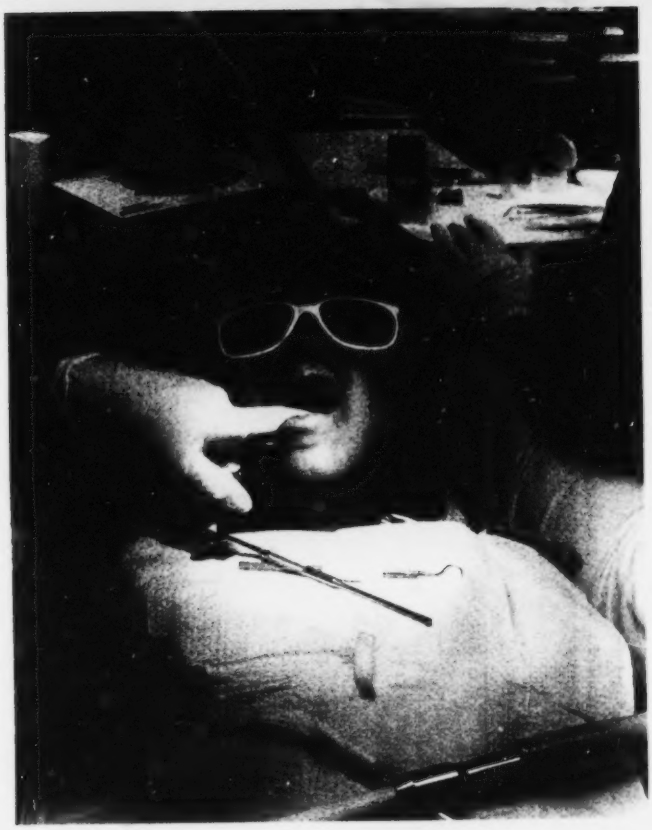
Access to oral health care is a significant problem for low-income children. Vulnerable children are more likely than children in general to have dental problems, including extensive tooth decay, pain, and infection. These problems can lead to eating, learning, and speech problems and are the cause of 52 million lost school hours each year.

Although dental problems can be prevented with regular screening and preventive services, these services are not always available to those children who most need them. In 1996, one in five children eligible for dental services under the Medicaid Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) program received a preventive dental service. Twenty-nine percent of 6-14 year olds eligible for EPSDT received a preventive dental service in 1996 compared to 18 percent of eligible children ages 1-5 and 15-20.

PERCENTAGE OF CHILDREN RECEIVING AN EPSDT PREVENTIVE DENTAL SERVICE: 1988–1996

Source (III.4): Health Care Financing Administration





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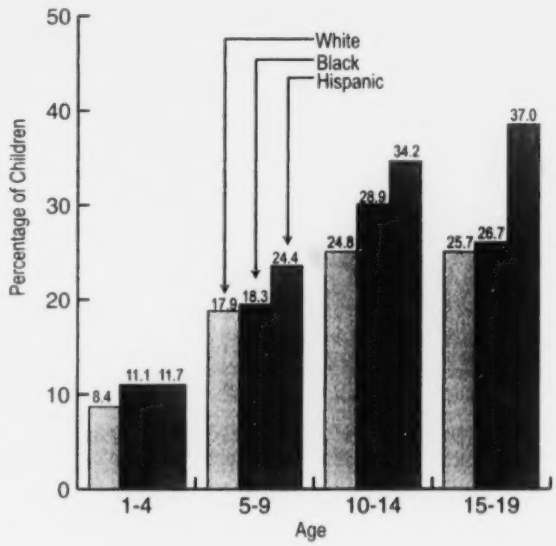
PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 1996

Source (III.5): National Center for Health Statistics



PHYSICIAN VISITS

In 1996, approximately 9 percent of preschoolers and 18 percent of children ages 5-9 had not been seen by a physician in the past year. Experts recommend that children see a doctor eight times in their first year, three times in their second year, and once a year until age six. In all age groups, a higher percentage of black and Hispanic children than white children had not been seen by a physician in the past year.

During 1996, 8.4 percent of white, 11.1 percent of black, and 11.7 percent of Hispanic-origin children ages 1-4 were not seen by a physician.

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PLACE OF PHYSICIAN CONTACT

Among children who saw a physician in the past year, children younger than 5 years old averaged nearly twice as many physician contacts as school-aged children.

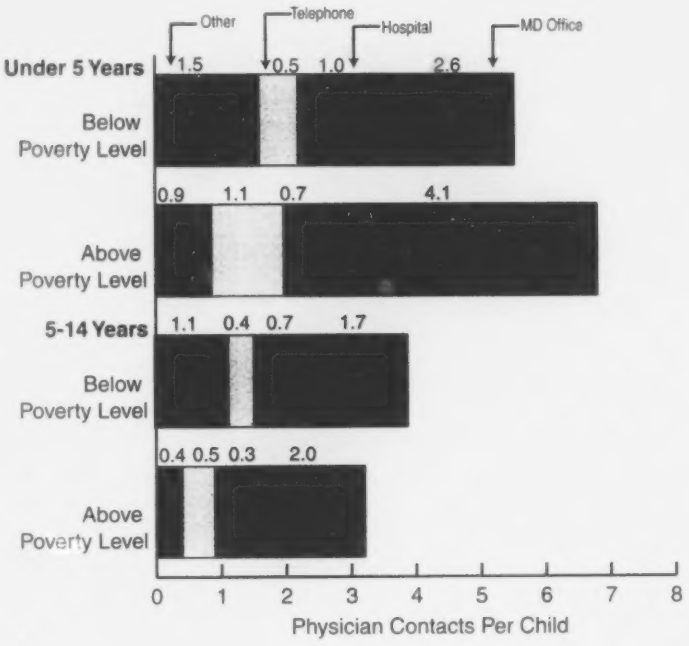
Children under 5 years of age whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and places other than physicians' offices than children above poverty.

From 1995 to 1996, the number of physician contacts per child in a physician's office for children in poverty, decreased for children under 5 and increased for children aged 5-14.

PLACE OF PHYSICIAN CONTACT BY AGE AND POVERTY STATUS: 1996

Source (HI.5): National Center for Health Statistics



ERVICE USE Y CHILDREN WITH HRONIC CONDITIONS

ysician Use

In 1996, children who were limited in their tivities* had three times as many physician ntacts as children without chronic condi-ons.** The number of physician contacts per rson for children without activity limitations mained stable from 1995 to 1996, while it creased for children under age 5 with activity limitations and decreased for teens and young adults with limitations.

Hospital Use

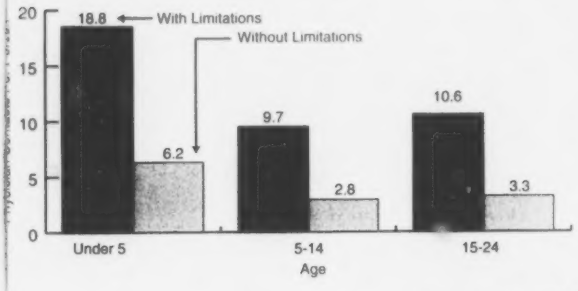
Children with activity limitations spend about 6 times as many days in the hospital as children without activity limitations.

*Limitation of activity is defined as the inability to participate in ordinary play for children less than 5 years old, or the inability to attend school for children 5 to 17 years old.

**Chronic conditions persist for more than three months. Conditions that are considered chronic regardless of their time of onset include diabetes and heart conditions.

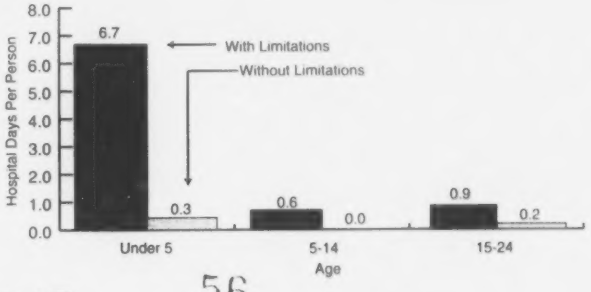
HYSICIAN UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY MITATIONS, BY AGE: 1996

urce (III.5): National Center for Health Statistics



HOSPITAL UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1996 (EXCLUDING DELIVERIES)

Source (III.5): National Center for Health Statistics



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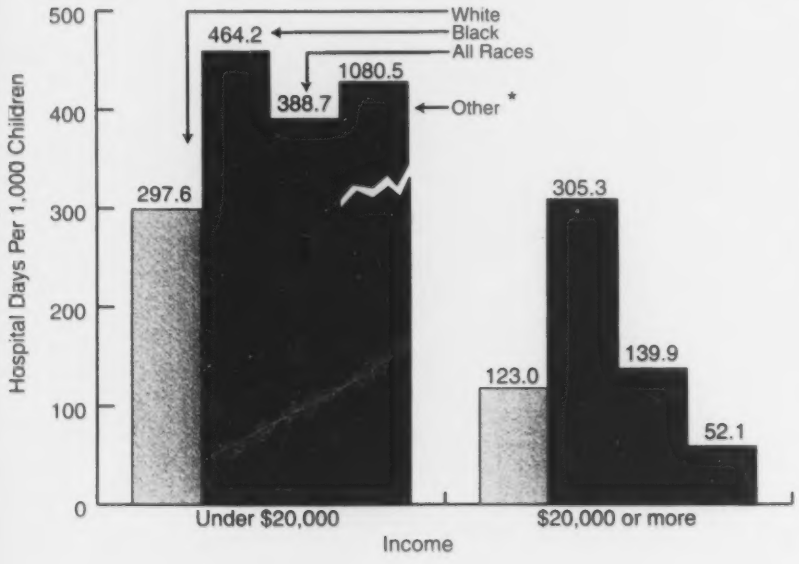
IOSPITAL UTILIZATION BY INCOME AND RACE: 1996

ource (III.5): National Center for Health Statistics



HOSPITAL UTILIZATION

In 1996, children younger than age 18 in families with incomes less than $20,000 averaged 2.8 times as many hospital days per 1,000 children as children in higher-income families.

For non-white, low-income children, and for black children with higher incomes, rates of hospital use increased from 1995-1996. For children with family incomes above $20,000, rates decreased for all racial groups except blacks.

Other includes: Indian, Eskimo, Aleut, Chinese, Filipino, Hawaiian, Korean, Vietnamese, Japanese, Asian Indian, Samoan, Guamanian, Other Asia Pacific Islanders, Other Race, Multiple Race, Unknown

PRENATAL CARE

Early Prenatal Care

The proportion of mothers beginning prenatal care in the first trimester of pregnancy increased for the eighth consecutive year, rising from 81.9 percent in 1996 to 82.5 percent in 1997.

In 1997, 84.7 percent of white mothers, as compared with 72.3 percent of black mothers, received early prenatal care. This represents a substantial racial disparity.

Women younger than 20 are much less likely than older women to receive early prenatal care.

Late or No Prenatal Care

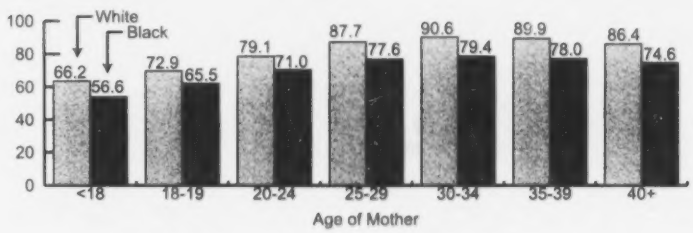
Every year from 1983 to 1991, 6 percent of all of infants were born to mothers who initiated care during the third trimester or received no prenatal care. However, that figure decreased to 4 percent in 1996 and remained at that level in 1997.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, unmarried status, low educational attainment, and minority group status.

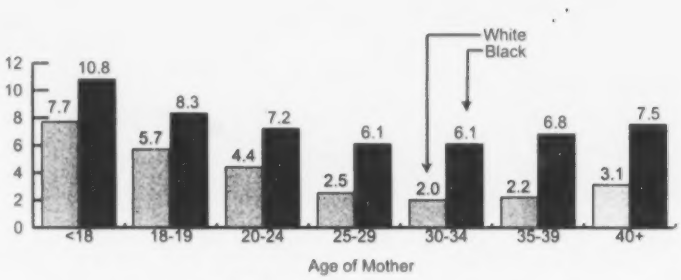
PERCENTAGE OF BIRTHS TO WOMEN WITH EARLY PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1997

Source (III.6): National Center for Health Statistics



PERCENTAGE OF BIRTHS TO WOMEN WITH LATE OR NO PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1997

Source (III.6): National Center for Health Statistics



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STATE DATA

While the indicators presented in the previous sections of this book are representative of the U.S. as a whole, the next section presents state-level health status indicators, data on infant, neonatal, and perinatal mortality, low birth weight, early prenatal care, births to women under 18, health care financing for children, and Medicaid enrollment and expenditures.

The following pages reveal stark disparities in the health status of children living in different states. In 1997, the national infant mortality rate (deaths per 1,000 live births) was 7.2. Among the 50 states, New Hampshire had the lowest rate (4.3), while the District of Columbia had the highest rate (13.2).

Women living in Alabama, Louisiana, Mississippi, South Carolina, Wyoming, and the District of Columbia were more likely to give birth to low birth weight babies (less than 2,500 grams or 5.5 pounds) than women in other regions of the country. These same states (with the exception of Wyoming) along with North Carolina and West Virginia, also had the highest rates of infant mortality.

Poverty in the U.S. has continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) assures that children living in poverty receive adequate health care services. In 1997, the District of Columbia had the greatest proportion of children with health care financed via Medicaid (38.2 percent) whereas Indiana had the smallest proportion (8.3 percent). The national average was 20.2 percent. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status.

The challenge to health care providers and policy-makers continues to be eliminating the disparities among states while improving the health status of children throughout the entire Nation.

INFANT AND NEONATAL MORTALITY RATES (1997) AND PERINATAL MORTALITY RATES (1996), BY RACE OF MOTHER AND STATE

Source (IV.1): National Center for Health Statistics

State	Infant Mortality[1]			Perinatal Mortality[2]			Neonatal Mortality[3]		
	All***	White	Black	All***	White	Black	All***	White	Black
UNITED STATES	**7.2**	**6.0**	**14.2**	**7.4**	**6.4**	**13.3**	**4.8**	**4.0**	**9.4**
ALABAMA	9.5	7.6	13.9	10.4	7.9	15.8	6.2	4.8	9.0
ALASKA	7.5	5.8	*	5.2	4.7	*	3.5	3.0	*
ARIZONA	7.1	6.8	14.4	6.9	6.6	16.1	4.5	4.5	9.6
ARKANSAS	8.7	7.4	13.8	8.5	7.8	11.5	5.2	4.2	9.2
CALIFORNIA	5.9	5.6	13.1	6.6	6.2	12.0	3.9	3.7	8.8
COLORADO	7.0	6.7	16.3	7.1	6.9	12.7	4.7	4.5	9.7
CONNECTICUT	7.2	6.3	14.3	7.2	6.5	13.5	5.6	4.9	11.4
DELAWARE	7.8	5.7	14.5	7.3	6.6	10.1	5.2	3.6	10.4
DC	13.2	*	16.7	13.7	*	16.4	9.7	*	12.4
FLORIDA	7.1	5.7	12.3	7.5	6.1	12.6	4.6	3.6	8.3
GEORGIA	8.6	6.1	13.8	9.0	6.5	13.8	6.0	4.2	9.7
HAWAII	6.6	*	*	5.5	5.0	*	4.2	*	*
IDAHO	6.8	6.9	*	7.5	7.6	*	4.3	4.3	*
ILLINOIS	8.4	6.4	17.1	8.4	6.9	14.8	5.6	4.4	10.9
INDIANA	8.2	7.3	15.8	8.8	8.4	13.3	5.3	4.8	9.9
IOWA	6.2	5.9	18.2	6.7	6.5	*	4.0	3.8	*
KANSAS	7.4	6.6	17.1	7.7	7.0	17.7	4.7	4.2	10.7
KENTUCKY	7.3	7.0	11.0	7.6	7.2	11.9	4.5	4.3	7.1
LOUISIANA	9.5	6.6	13.8	8.6	6.6	11.5	6.2	4.2	9.1
MAINE	5.1	5.3	*	5.7	5.6	*	3.4	3.5	*
MARYLAND	8.8	5.1	16.2	8.6	5.9	14.0	6.3	3.5	11.8
MASSACHUSETTS	5.2	5.0	8.8	6.1	6.0	8.5	4.0	3.9	6.2
MICHIGAN	8.2	6.1	17.5	7.0	5.7	12.8	5.6	4.4	11.6
MINNESOTA	5.9	5.1	16.5	6.1	5.5	14.4	3.8	3.3	9.9
MISSISSIPPI	10.6	7.1	14.9	10.8	8.0	14.1	6.5	4.4	9.0
MISSOURI	7.6	6.1	16.3	7.0	6.3	11.8	4.8	3.8	10.4
MONTANA	6.9	6.0	*	6.5	6.3	*	3.6	3.8	*
NEBRASKA	7.4	6.8	19.2	8.8	8.6	*	5.3	4.8	*
NEVADA	6.5	6.2	13.6	5.3	4.9	*	3.9	3.8	*
NEW HAMPSHIRE	4.3	4.3	*	5.3	5.2	*	3.2	3.2	*
NEW JERSEY	6.3	4.9	13.4	7.2	6.0	13.3	4.5	3.7	9.1
NEW MEXICO	6.1	5.6	*	5.5	5.5	*	3.3	3.1	*
NEW YORK	6.7	5.7	10.9	7.9	6.9	12.9	4.7	4.1	7.4
NORTH CAROLINA	9.2	6.9	15.7	9.6	7.7	15.2	6.5	4.8	11.0
NORTH DAKOTA	6.2	5.9	*	6.3	6.1	*	3.6	3.9	*
OHIO	7.6	6.5	15.6	7.8	6.7	14.5	5.2	4.5	9.8
OKLAHOMA	7.5	6.7	15.0	8.0	7.9	11.6	4.5	4.2	8.6
OREGON	5.8	5.7	*	6.1	6.0	*	3.6	3.7	*
PENNSYLVANIA	7.6	6.0	17.6	8.2	7.1	14.4	5.3	4.1	12.6
RHODE ISLAND	7.0	7.0	*	6.6	6.9	*	5.5	5.5	*
SOUTH CAROLINA	9.6	6.4	15.4	9.8	6.2	16.6	6.9	4.7	10.9
SOUTH DAKOTA	7.7	5.3	*	6.3	5.0	*	3.8	3.2	*
TENNESSEE	8.6	6.5	16.3	8.1	6.6	13.8	5.1	3.8	9.8
TEXAS	6.4	5.9	10.9	6.0	5.5	10.1	3.8	3.5	6.2
UTAH	5.8	5.8	*	5.8	5.8	*	3.8	3.8	*
VERMONT	6.1	6.1	*	7.4	7.5	*	4.2	4.3	*
VIRGINIA	7.8	6.0	14.2	7.6	5.9	13.8	5.5	4.2	10.2
WASHINGTON	5.6	5.3	15.4	6.2	5.9	14.0	3.4	3.3	7.2
WEST VIRGINIA	9.6	9.1	*	7.4	7.2	*	6.4	6.1	*
WISCONSIN	6.5	5.7	13.9	7.7	6.8	14.7	4.4	4.0	8.7
WYOMING	5.8	5.6	*	8.2	8.0	*	3.1	*	*

* *Figure does not meet standards of reliability or precision*

** *Quantity zero*

*** *Includes races other than white or black*

1 Rates are deaths less than one year per 1,000 live births in specified group.

2 Rates are fetal deaths ≥ 28 weeks and infant deaths < 7 days per 1,000 live births.

3 Rates are deaths under 28 days per 1,000 live births in specified group.

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PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT, WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE, AND BIRTHS TO WOMEN UNDER 18, BY RACE OF MOTHER AND STATE: 1997

Source (IV.2): National Center for Health Statistics

	Percentage Low Birth Weight			Percentage with Early Prenatal Care			Percentage of Births to Women < 18			
State	All***	White	Black	All***	White	Black	All***	White	Black	Hispanic
UNITED STATES†	**7.5**	**6.5**	**13.0**	**82.5**	**84.7**	**72.3**	**4.9**	**4.1**	**9.7**	**7.2**
ALABAMA	9.2	7.4	13.1	82.2	88.0	70.3	7.1	4.9	11.7	5.2
ALASKA	5.9	5.5	12.3	80.4	82.4	81.3	3.9	2.8	6.6	4.3
ARIZONA	6.9	6.6	13.6	75.4	76.5	70.9	6.0	5.8	9.0	8.9
ARKANSAS	8.4	7.2	12.7	75.7	79.4	62.6	7.2	5.5	13.6	7.3
CALIFORNIA	6.2	5.6	12.0	81.8	81.8	78.6	4.6	4.7	7.1	6.6
COLORADO	8.8	8.5	15.1	82.9	83.3	77.3	4.6	4.5	7.7	10.1
CONNECTICUT	7.3	6.5	12.3	89.2	90.6	80.1	3.3	2.7	8.2	9.7
DELAWARE	8.7	6.9	14.1	82.5	86.2	71.4	5.5	3.6	11.5	5.0
DC	13.4	5.9	16.1	66.6	81.0	61.4	6.7	2.4	7.2	6.1
FLORIDA	8.0	6.8	12.3	83.9	87.1	72.8	5.2	4.0	9.8	5.0
GEORGIA	8.8	6.6	13.0	85.8	89.5	78.5	6.4	4.3	10.6	5.7
HAWAII	7.2	5.1	10.2	83.4	88.9	89.2	3.5	1.3	*	6.8
IDAHO	6.3	6.3	*	78.6	78.9	71.0	4.2	4.2	*	7.8
ILLINOIS	7.9	6.4	13.9	82.4	85.6	69.7	5.0	3.4	12.1	6.3
INDIANA	7.7	7.0	13.6	80.1	81.8	66.1	5.2	4.5	11.4	7.4
IOWA	6.4	6.2	10.4	87.4	88.1	73.5	3.8	3.4	12.3	6.2
KANSAS	6.9	6.4	12.9	85.6	86.6	75.9	4.6	4.1	11.3	8.3
KENTUCKY	7.8	7.4	12.0	85.8	86.8	75.3	5.9	5.5	11.4	5.5
LOUISIANA	10.2	7.0	14.6	81.3	88.6	71.1	7.3	4.6	11.1	5.5
MAINE	5.9	5.9	*	88.9	89.3	79.0	3.0	3.0	*	*
MARYLAND	8.8	6.4	13.6	88.8	92.6	80.3	4.2	2.4	8.1	4.0
MASSACHUSETTS	7.0	6.6	10.6	88.9	90.4	78.0	2.8	2.4	6.1	9.7
MICHIGAN	7.7	6.5	13.2	84.2	87.2	70.6	4.2	3.2	9.2	7.7
MINNESOTA	5.9	5.5	11.1	84.1	86.7	63.8	3.1	2.3	10.5	7.8
MISSISSIPPI	10.1	7.4	13.4	80.1	89.2	69.6	8.8	5.1	13.2	*
MISSOURI	7.7	6.7	13.5	86.0	88.2	73.6	5.0	4.0	10.9	6.8
MONTANA	6.3	6.1	*	82.6	84.8	84.9	4.1	3.1	*	8.0
NEBRASKA	7.0	6.7	11.7	83.9	85.0	72.0	3.8	3.2	12.9	6.6
NEVADA	7.6	7.0	13.7	76.1	76.9	66.6	5.4	4.9	11.0	7.0
NEW HAMPSHIRE	5.8	5.9	*	89.6	89.8	78.0	2.4	2.4	*	*
NEW JERSEY	7.9	6.5	13.7	81.3	85.5	63.9	3.0	2.0	8.0	6.1
NEW MEXICO	7.8	7.8	15.4	70.2	72.5	64.2	7.3	7.4	10.3	9.7
NEW YORK	7.8	6.7	11.8	80.6	84.1	69.8	3.3	2.7	6.1	5.8
NORTH CAROLINA	8.8	7.1	13.6	83.9	88.1	73.2	5.5	4.0	9.6	6.5
NORTH DAKOTA	6.2	6.2	*	84.8	86.7	75.0	2.7	2.1	*	*
OHIO	7.7	6.7	13.6	85.1	87.4	72.2	4.8	3.8	10.9	7.7
OKLAHOMA	7.3	6.8	12.3	78.5	81.1	67.7	6.2	5.3	11.5	8.2
OREGON	5.3	5.3	11.0	81.1	81.4	79.4	4.6	4.4	9.5	8.4
PENNSYLVANIA	7.6	6.5	13.9	83.8	86.6	68.0	3.9	2.8	10.2	11.0
RHODE ISLAND	7.4	6.9	11.9	89.5	90.6	79.9	4.3	3.8	7.2	9.9
SOUTH CAROLINA	9.2	6.8	13.5	80.5	87.0	68.8	6.6	4.4	10.5	6.9
SOUTH DAKOTA	5.5	5.6	*	82.1	85.2	69.2	4.1	3.0	*	*
TENNESSEE	8.8	7.4	13.7	83.7	87.1	71.8	6.1	4.7	11.3	6.3
TEXAS	7.3	6.5	12.4	78.5	78.8	74.6	6.7	6.4	10.1	8.8
UTAH	6.6	6.5	13.8	83.7	84.6	70.2	3.5	3.4	10.0	7.8
VERMONT	6.3	6.3	*	88.0	88.2	*	2.4	2.5	*	*
VIRGINIA	7.7	6.2	12.6	85.1	88.8	73.5	4.0	2.7	8.7	4.5
WASHINGTON	5.6	5.3	10.2	83.3	84.1	77.1	4.0	3.8	7.4	7.5
WEST VIRGINIA	8.3	8.1	12.8	82.0	82.6	65.3	5.3	5.2	10.7	*
WISCONSIN	6.4	5.6	13.3	84.6	87.3	68.9	4.1	2.8	13.6	8.4
WYOMING	9.0	9.0	*	82.5	83.2	75.8	4.8	4.6	*	8.9

** figure does not meet standards of reliability or precision*
*** data not available*
† excludes data for Puerto Rico, Virgin Islands, and Guam
**** includes races other than white and black*

MEDICAID ENROLLEES, EXPENDITURES, AND REPORTED EPSDT UTILIZATION FOR CHILDREN UNDER AGE 21, FY 1997

Source (IV.3): American Academy of Pediatrics

State	Medicaid Enrollees	Per Child-Enrollee* Expenditures**	% Medicaid Enrollees Who Used EPSDT Services***
UNITED STATES	**22,729,432**	**$1,239**	**27.5**
ALABAMA	410,498	$551	31.9
ALASKA	49,760	$1,987	1.9
ARIZONA	431,637	NA	58.2
ARKANSAS	211,509	$1,056	39.1
CALIFORNIA	3,541,295	$938	21.1
COLORADO	203,049	$1,324	20.5
CONNECTICUT	212,059	$1,701	4.1
DELAWARE	58,334	$770	34.7
DC	80,735	$1,477	2.0
FLORIDA	1,194,290	$951	20.0
GEORGIA	773,398	$1,002	39.8
HAWAII	0	NA	NA
IDAHO	73,195	$870	19.9
ILLINOIS	1,108,986	$930	44.5
INDIANA	358,739	$600	0.0
IOWA	170,970	$1,095	42.4
KANSAS	152,788	$1,066	53.0
KENTUCKY	343,438	$1,255	16.0
LOUISIANA	459,408	$2,177	46.6
MAINE	94,030	$1,847	42.5
MARYLAND	220,095	$1,996	42.5
MASSACHUSETTS	389,315	$1,388	13.8
MICHIGAN	785,525	$848	18.2
MINNESOTA	353,734	$1,461	7.8
MISSISSIPPI	307,460	$715	50.9
MISSOURI	465,834	$424	20.6
MONTANA	53,019	$810	25.1
NEBRASKA	124,091	$975	28.4
NEVADA	79,714	$1,237	36.5
NEW HAMPSHIRE	60,678	$1,345	25.0
NEW JERSEY	456,720	$893	4.2
NEW MEXICO	233,321	$1,184	19.2
NEW YORK	1,693,941	$2,123	32.0
NORTH CAROLINA	670,968	$1,190	57.7
NORTH DAKOTA	33,792	$1,216	0.0
OHIO	820,116	$1,316	17.6
OKLAHOMA	247,644	NA	$0.0
OREGON	262,650	$1,916	90.3
PENNSYLVANIA	895,506	$1,242	22.0
RHODE ISLAND	76,544	$402	5.4
SOUTH CAROLINA	327,629	$1,041	31.4
SOUTH DAKOTA	53,660	$977	23.9
TENNESSEE	653,484	NA	0.0
TEXAS	1,794,065	$1,681	47.2
UTAH	113,902	$790	0.0
VERMONT	61,989	$899	54.7
VIRGINIA	431,054	$809	21.2
WASHINGTON	561,023	$1,071	1.2
WEST VIRGINIA	220,237	$984	32.8
WISCONSIN	320,044	$1,475	13.0
WYOMING	33,560	$946	26.5

*"Children" as defined by HCFA based on age and other factors. ** Does not include Disproportionate Share Hospital Payments *** Percents smaller than 0.05 are rounded to zero. Under-reporting of Early Periodic Screening Diagnosis and Treatmen (EPSDT) services is known to be a problem in some states due to complexities in the reporting process. "NA" Data unavailable Per child-enrollee expenditures was $1,136 for Arizona, $2,654 for Oklahoma and $936 for Tennessee in FY 1996. States with missing FY 1997 data are not included in computation of the U.S. average.

HEALTH INSURANCE STATUS FOR CHILDREN UNDER AGE 19: 1997

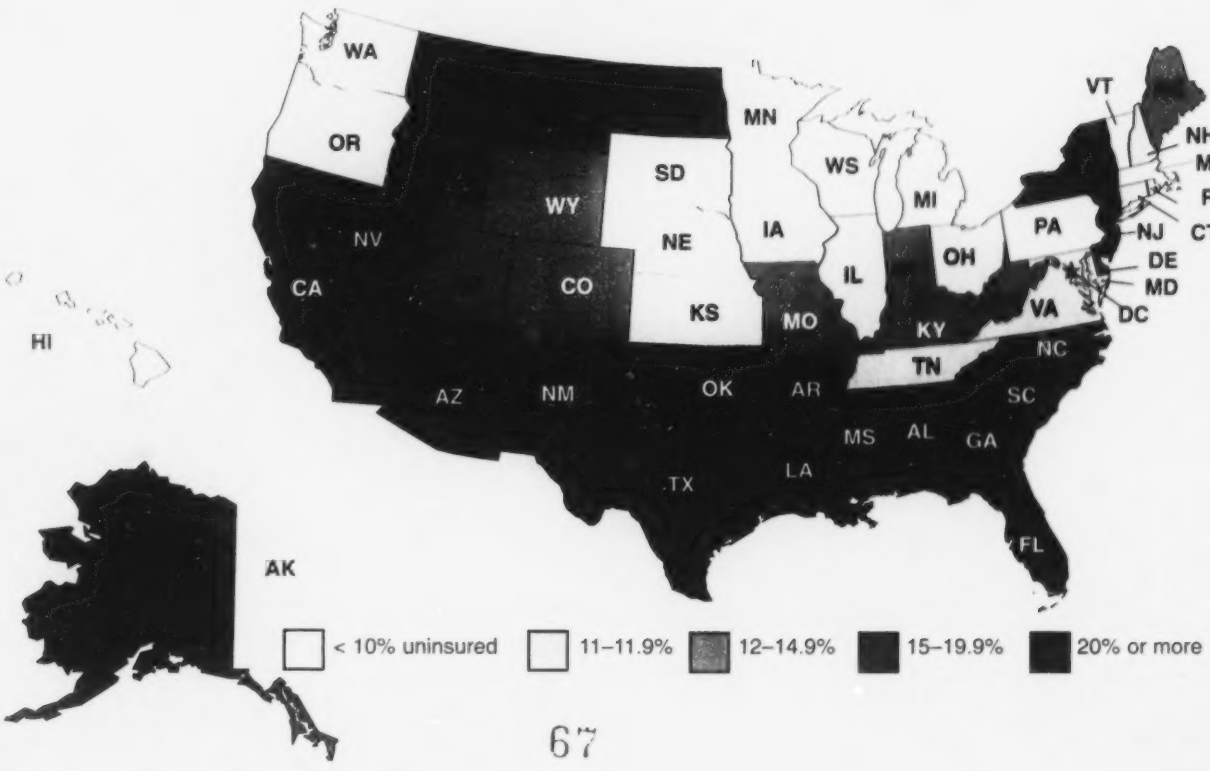
Source (IV.4): American Academy of Pediatrics

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid	Percent Uninsured*
UNITED STATES	**64.4**	**20.2**	**15.3**
ALABAMA	64.7	19.8	15.4
ALASKA	70.7	14.3	15.0
ARIZONA	55.7	16.9	27.4
ARKANSAS	52.3	19.7	28.0
CALIFORNIA	56.7	24.5	18.8
COLORADO	75.6	10.3	14.1
CONNECTICUT	76.8	11.4	11.8
DELAWARE	63.2	22.5	14.3
DC	47.5	38.2	14.3
FLORIDA	62.2	17.5	20.3
GEORGIA	57.2	26.0	16.8
HAWAII	74.0	20.5	5.5
IDAHO	64.6	16.2	19.2
ILLINOIS	71.5	17.4	11.1
INDIANA	79.1	8.3	12.7
IOWA	75.9	12.9	11.2
KANSAS	77.6	12.2	10.2
KENTUCKY	61.3	24.6	14.1
LOUISIANA	58.5	18.6	22.9
MAINE	67.4	17.7	14.9
MARYLAND	77.7	11.9	10.4
MASSACHUSETTS	64.6	26.2	9.2
MICHIGAN	67.5	23.9	8.6
MINNESOTA	67.2	25.2	7.6
MISSISSIPPI	59.4	21.5	19.1
MISSOURI	70.4	16.5	13.1
MONTANA	64.5	17.6	17.9
NEBRASKA	71.0	19.0	10.0
NEVADA	69.4	10.5	20.1
NEW HAMPSHIRE	72.2	17.5	10.3
NEW JERSEY	70.2	13.9	15.9
NEW MEXICO	49.7	30.4	19.9
NEW YORK	58.4	25.8	15.8
NORTH CAROLINA	63.0	18.7	18.3
NORTH DAKOTA	69.8	13.2	16.9
OHIO	73.6	15.8	10.6
OKLAHOMA	66.8	15.5	17.6
OREGON	70.1	18.5	11.4
PENNSYLVANIA	69.0	22.5	8.5
RHODE ISLAND	70.4	21.4	8.1
SOUTH CAROLINA	62.2	18.9	18.8
SOUTH DAKOTA	75.5	15.0	9.5
TENNESSEE	56.0	32.9	11.1
TEXAS	54.1	20.7	25.2
UTAH	77.0	10.3	12.7
VERMONT	62.3	31.0	6.6
VIRGINIA	69.9	18.2	11.9
WASHINGTON	66.8	25.2	7.9
WEST VIRGINIA	59.9	27.5	12.6
WISCONSIN	82.7	12.3	5.1
WYOMING	72.5	13.1	14.3

*See map on facing page

PERCENTAGE OF UNINSURED CHILDREN UNDER THE AGE OF 19: 1997

Source (IV.4): American Academy of Pediatrics



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CITY DATA

How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight, and prenatal care for women and children who reside in the Nation's central cities with populations over 100,000.

As the following data indicate, the health status of children living in large U.S. cities is generally inferior to that of children in the Nation as a whole. While the infant mortality rate has decreased in both cities and the Nation, a disparity in rates remains. Higher rates of low birth weight contributed to the 1997 city infant mortality rate of 8.2 deaths per 1,000 live births; the national rate was 7.2. The percentage of pregnant women receiving first trimester prenatal care is lower in cities (78.9 percent) as compared to the Nation (82.5 percent). The percentage of women receiving late or no prenatal care is nearly one quarter higher in cities than in the Nation as a whole (5.1 percent versus 3.9 percent).

The challenge for health care providers and special initiatives is to eliminate these disparities by improving the health status of children in the Nation's cities.

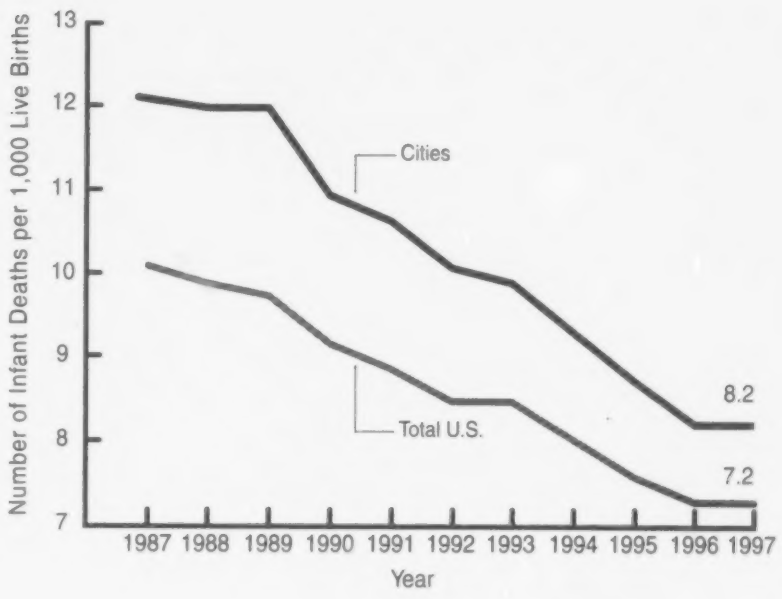
INFANT MORTALITY

In 1997, 9,758 infants born to residents of U.S. cities with populations over 100,000 died in the first year of life. The city infant mortality rate was 8.2 deaths per 1,000 live births, 12 percent higher than the rate of 7.2 for the Nation as a whole. The 1997 rate of 8.2 represents an almost 6 percent decrease in the 1995 city infant mortality rate of 8.7.

Although the infant mortality rate in cities has routinely been higher than the rate in the Nation as a whole, it has steadily declined over the past decade. Between 1987 and 1997, infant mortality in cities declined more than 32 percent; the decline nationwide in the same period was approximately 28 percent.

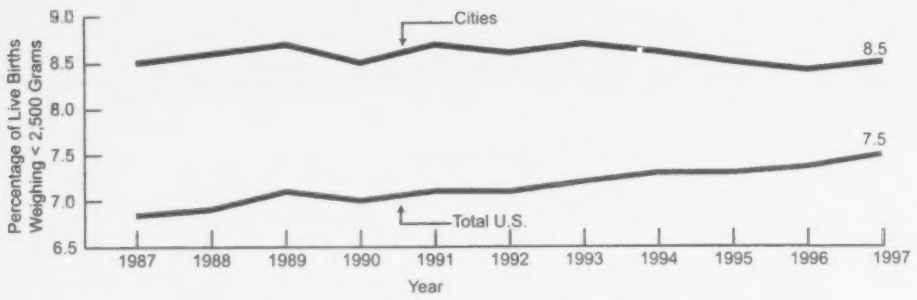
INFANT MORTALITY RATES IN U.S. CITIES WITH POPULATION OVER 100,000: 1987–1997

Source (V.1): National Center for Health Statistics



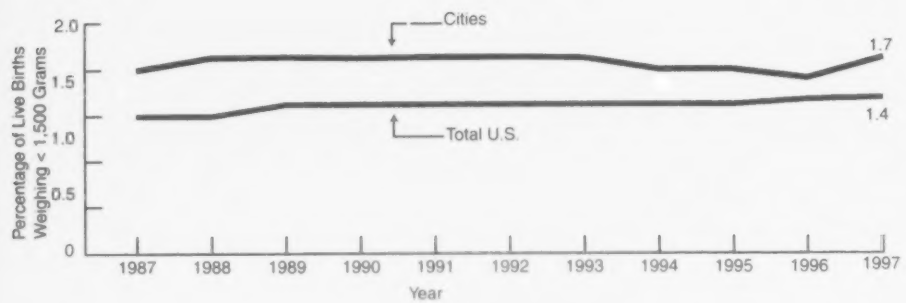
PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1997

Source (V.1): National Center for Health Statistics



PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1997

Source (V.1): National Center for Health Statistics



BIRTH WEIGHT

Low Birth Weight

Disorders related to short gestation and low birth weight are the number two cause of neonatal mortality.* In 1997, 101,314 babies (8.5 percent of all live births) born to residents of U.S. cities with populations over 100,000 were of low birth weight (weighing less than 2,500 grams or 5.5 pounds). The 1997 percentage of urban infants with low birth weight was 13 percent higher than the national percentage of 7.5 percent.

Very Low Birth Weight

Infants with very low birth weight (less than 1,500 grams or 3 pounds, 5 ounces) are at highest risk for poor health outcomes. In 1997, 1.7 percent of live births in cities with populations over 100,000 were of very low birth weight. This rate exceeded the national very low birth weight rate by nearly 21 percent. The national rate of very low birth rate remained stable from 1996 to 1997.

*Congenital anomalies are the leading cause of neonatal mortality.

PRENATAL CARE

Early Prenatal Care

Women living in U.S. cities with a population of over 100,000 are less likely to begin prenatal care in the first three months of pregnancy than women nationwide. The gap in early entry into prenatal care between urban women and the nation as a whole has narrowed since 1993.

In 1997, 78.9 percent of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 82.5 percent nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The corollary Healthy People 2000 Objective is to have 90 percent of pregnant women begin prenatal care in the first trimester.

Late or No Prenatal Care

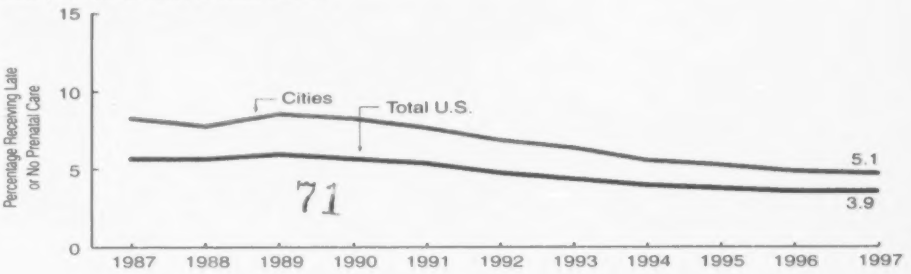
The percentage of pregnant women living in U.S. cities with a population of over 100,000 who began prenatal care in the 3rd trimester or received no prenatal care decreased from 5.3 percent to 5.1 percent between 1996 and 1997. However, the percentage of women receiving late or no prenatal care is still 31 percent higher among women living in cities than among the overall U.S. population.

PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1997

Source (V.1): National Center for Health Statistics

PERCENTAGE OF PREGNANT WOMEN RECEIVING LATE OR NO PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1997

Source (V.1): National Center for Health Statistics



PROGRESS TOWARDS HEALTHY PEOPLE 2000 OBJECTIVES FOR THE NATION

Source (V1.1): Public Health Service

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE		1997 (OR MOST CURRENT) STATISTIC
Adolescent Physical Activity	Percentage of high school students who participated in moderate physical activity (30 minutes/day) 5 of the 7 previous days **(page 33)**	1.3	At least 30% of people ages 6 and older engage regularly or daily in light to moderate physical activity for at least 30 minutes/day	9th grade: (F) 27.6% (M) 28.6% 10th grade: (F) 20.8% (M) 23.7% 11th grade: (F) 17.0% (M) 17.8% 12th grade: (F) 14.2% (M) 15.3%
Adolescent Smoking	Thirty-day prevalence of cigarette smoking for 8th–12th graders **(page 44)**	3.5	No more than 15% of adolescents become regular smokers by age 20	(1998) 8th grade: 19.1% 10th grade: 27.6% 12th grade: 35.1%
Adolescent Substance Abuse	Thirty-day prevalence of alcohol, marijuana and cocaine use by adolescents ages 12–17 **(page 45)**	4.6	Use in past month by adolescents (ages 12–17) Alcohol 12.6% Marijuana: 3.2% Cocaine 0.6%	(1998) Alcohol: 19.1% Marijuana: 8.3% Cocaine: 0.8%
Adolescent Childbearing	Live births per 1,000 female adolescents ages 10–19 **(page 38)**	5.1	No more than 50 *pregnancies* per 1,000 girls ages 15–17	32.1 *live births* per 1,000 girls ages 15–17

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Adolescent Sexual Activity	Percentage of students in grades 9–12 who have ever had sexual intercourse **(page 36)**	5.4 No more than 15% by age 15 No more than 40% by age 17	(1995) 9th grade (F) 34.0%; (M) 41.8% 10th grade (F) 43.5%; (M) 41.7% 11th grade (F) 50.3%; M) 49.3% 12th grade (F) 61.9%; (M) 60.1%
Adolescent Firearm Mortality	Deaths by firearms per 100,000 adolescents (ages 15–19) **(page 35)**	Deaths per 100,000 adolescents (ages 15–19): 6.1 No more than 8.2 suicides 7.3 No more than 12.9 firearm-related deaths	Firearm deaths per 100,000 adolescents (15–19): Homicide 11.7 Suicide 6.0 Unintentional .9
Hospitalization	Number of hospital discharges among children, by illness **(page 28)**	6.3 Less than 17% prevalence of mental disorders among children and adolescents 11.1b No more than 225 per 100,000 children aged 14 and younger hospitalized for asthma	4.0 discharges per 100 children 242,000 discharges due to mental disorder (ages 10–21) 505,000 discharges for respiratory disease (ages 1–19)

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Child Abuse	Cases per 1,000 children under 18 **(page 31)**	7.4 Incidence of maltreatment of children under age 18 of less than 22.6 per 1,000	13.9 cases per 1,000 children under age 18
		Rate of abuse per 1,000 children under age 18 by type of abuse:	Percentage of total by type of abuse:
		7.4a Physical, less than 4.9	Physical 24.5%
		7.4b Sexual, less than 12.1	Sexual 12.2%
		7.4c Emotional, less than 3.0	Emotional 6.2%
		7.4d Neglect, less than 14.6	Neglect 57.1%
School Dropout Rates	Percentage of adolescents (ages 16–24) not enrolled/completed high school **(page 16)**	8.2 At least 90% high school completion rate	Dropout rate for ages 16–24: Hispanic 25.3% Black 13.4% White 7.6%
Child Injury Mortality	Injury-related deaths per 100,000 children in specified age group **(page 27)**	9.3a No more than 4.4 motor vehicle deaths per 100,000 children under 15	Deaths per 100,000 population:
		9.5a No more than 2.3 deaths due to drowning, fires, and burns: deaths per 100,000 children4 and younger	Ages 1–4 5–14 Vehicle crashes 4.3 4.8 Drowning 3.1 1.2 Fire-related deaths 2.5 0.8
		9.6a No more than 3.3 fire-related deaths per 100,000 children 4 and younger	

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Adolescent Mortality	Leading causes of deaths per 100,000 adolescents (ages 15–19) **(page 34)**	(Age Related Objective): No more than 85 deaths per 100,000 adolescents ages 15-24	Deaths per 100,000 adolescents (ages 15–19): 74.8
		9.3b No more than 26.8 deaths by motor vehicle crashes per 100,000 adolescents ages 15–24	Motor vehicle crashes 27.3
Infant Mortality	Infant deaths per 1,000 live births **(page 21)**	14.1 No more than 7 deaths per 1,000 live births	7.2 deaths per 1,000 live births
Postneonatal Mortality	Deaths per 100,000 live births among infants ages 28 days to 11 months **(page 22)**	14.1g No more than 2.5 postneonatal deaths per 1,000 live births	2.5 deaths per 1,000 live births
Neonatal Mortality	Deaths of infants less than 28 days old per 100,000 live births **(page 22)**	14.1 No more than 4.5 deaths per 1,000 live births	4.8 deaths per 1,000 live births
Maternal Mortality	Maternal deaths per 100,000 live births **(page 23)**	14.3 No more than 3.3 deaths per 100,000 live births	8.4 deaths per 100,000 live births
Low Birth Weight	Percentage of live births less than 2.500 grams (5.5 lbs) **(page 18)**	14.5 No more than 5% of live births	7.5% of all live births

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Infant Feeding	Breastfeeding in hospital and 5–6 months postpartum **(page 24)**	14.9 75% in hospital; 50% at 5–6 months postpartum	62.4% in hospital 26% at 5–6 months postpartum 5–6 month postpartum by race: Hispanic: 24.5% White: 28.6% Black: 14.5%
Prenatal Care	Initiation of prenatal care in the first trimester **(page 58)**	14.1 90% of all pregnant women	82.5% of births were to women who received care in the first trimester
Adolescent Condom Use	Percentage of high school students using a condom during last intercourse **(page 36)**	18.4 Condom used during last intercourse: Young women (15–19): 60%; young men (15–19): 75%	9th grade 58.8% 10th grade 58.9% 11th grade 60.1% 12th grade 52.4%
Adolescent Sexually Transmitted Diseases	Cases of gonorrhea per 100,000 adolescents (ages 15-19) **(page 39)**	19.1b Per 100,000 adolescents (ages 15–19): Gonorrhea: No more than 375	530 cases per 100,000 adolescents (ages 15–19

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Vaccination	Coverage levels among children (ages 19–35 months) **(page 48)**	20.11 At least 90% of basic immunization series among children under age 2	(1997-1998) Children (19–35 months) receiving vaccinations: DTP 95% Polio 91% Hib 93% MCV 91% Hep B 85% Var 34%
Physician Visits	Percentage of children with no physician visits in past year **(page 52)**	Population receiving basic preventive services: 21.2a Up to 24 months 90% 21.2b Ages 2–12 80% 21.2c Ages 13–18 50%	Children seen by physician in past year Ages 1-4 years 91.1% Ages 5-9 years 82.0% Ages 10-14 years 74.9% Ages 15-19 years 74.2%

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1997 (OR MOST CURRENT) STATISTIC
Health Insurance Coverage	Percentage of children under 18 with no insurance coverage **(page 47)**	21.3 95% of population have source of ongoing primary care 21.4 No citizen has financial barrier to receiving preventive services	15% of children under 18 uninsured (10.6 million children nationally)
Child Mortality	Deaths due to leading causes in specified age group **(page 26)**	(Age-related objective): No more than 28 deaths per 100,000 children ages 1–14	Deaths per 100,000 children: 26.3 Ages 1–4: 24.0 Ages 5–14: 15.7

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